

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**17294**

**CERTIFICATE OF DEATH**

**17285**

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 16 <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>MONTGOMERY</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash San + Hospital</i>		e. STREET ADDRESS <i>7809 Garland Ave</i>		f. DATE OF DEATH <i>12 24 1966</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>FRED Eugene Adams</i>		First	Middle	Last	Month	Day	Year			
4. SEX <i>Male</i>		5. COLOR OR RACE <i>white</i>	6. MARRIED <input checked="" type="checkbox"/> WIDOWED	7. NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>11-17-1877</i>	9. AGE (In years last birthday) <i>89</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>	13. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maine</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>				
13. FATHER'S NAME <i>George Washington Adams</i>		14. MOTHER'S MAIDEN NAME <i>Julia Choate</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Daughter - Miss Esther Adams</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Coronary thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i>				
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Generalized arteriosclerosis</i>		DUE TO <i>15 yrs.</i>						
DUE TO <i>(c)</i>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>										
21. I certify that (I) (this hospital) attended the deceased from <i>July 17 1966</i> to <i>Dec 24 1966</i> , that (I) (we) last saw the deceased alive on <i>Dec 21 1966</i> , and that death occurred at <i>7809 Garland Ave.</i> M, fram causes and on the date stated above.										
22a. SIGNATURE <i>James Whitlock</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12-24-66</i>						
22c. PHYSICIAN'S NAME (Type) <i>JAMES WHITLOCK</i>		22d. ADDRESS <i>7717 Canfield Takoma Park MD</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 27 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>George Washington Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Lloyd Park Md.</i>				
24. FUNERAL DIRECTOR <i>Arthur Walters</i>		ADDRESS <i>254 Carroll Street, Inc.</i>		25a. REC'D BY REGISTRAR <i>DEC 29 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17295

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17286

1. PLACE OF DEATH <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park, Md.</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
99		d. STREET ADDRESS <b>4203 Oglethorpe Street</b>	
3. NAME OF DECEASED (Type or print) <b>Maria Clare Alexandre</b>		4. DATE OF DEATH <b>12-18-66</b>	
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>No</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Antonio Alexandre</b>		14. MOTHER'S MAIDEN NAME <b>Carmelia F. Medeiros</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Antonio Alexandre (father)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation due to</b> 9240 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>face becoming wedged between mattress and crib frame.</b>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Infant, face down, became wedged between mattress and crib frame</b>	
20c. TIME OF INJURY Month, Day, Year <b>6 p.m. 12-18-66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		20f. (City or town) <b>Hyattsville</b> (County) <b>Prince</b> (State) <b>Md.</b>	
ACTUAL SIGNATURE <b>Belden Reap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D. Hyattsville</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>12/19/1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 20, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt Olivet Cemetery</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>DEC 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

12581

22500

at cross-tightening

3rd. In place - pinned with  
- many fasteners

2nd. In place - pinned with  
- many fasteners X 22-21323

3rd. In place X 22-21323

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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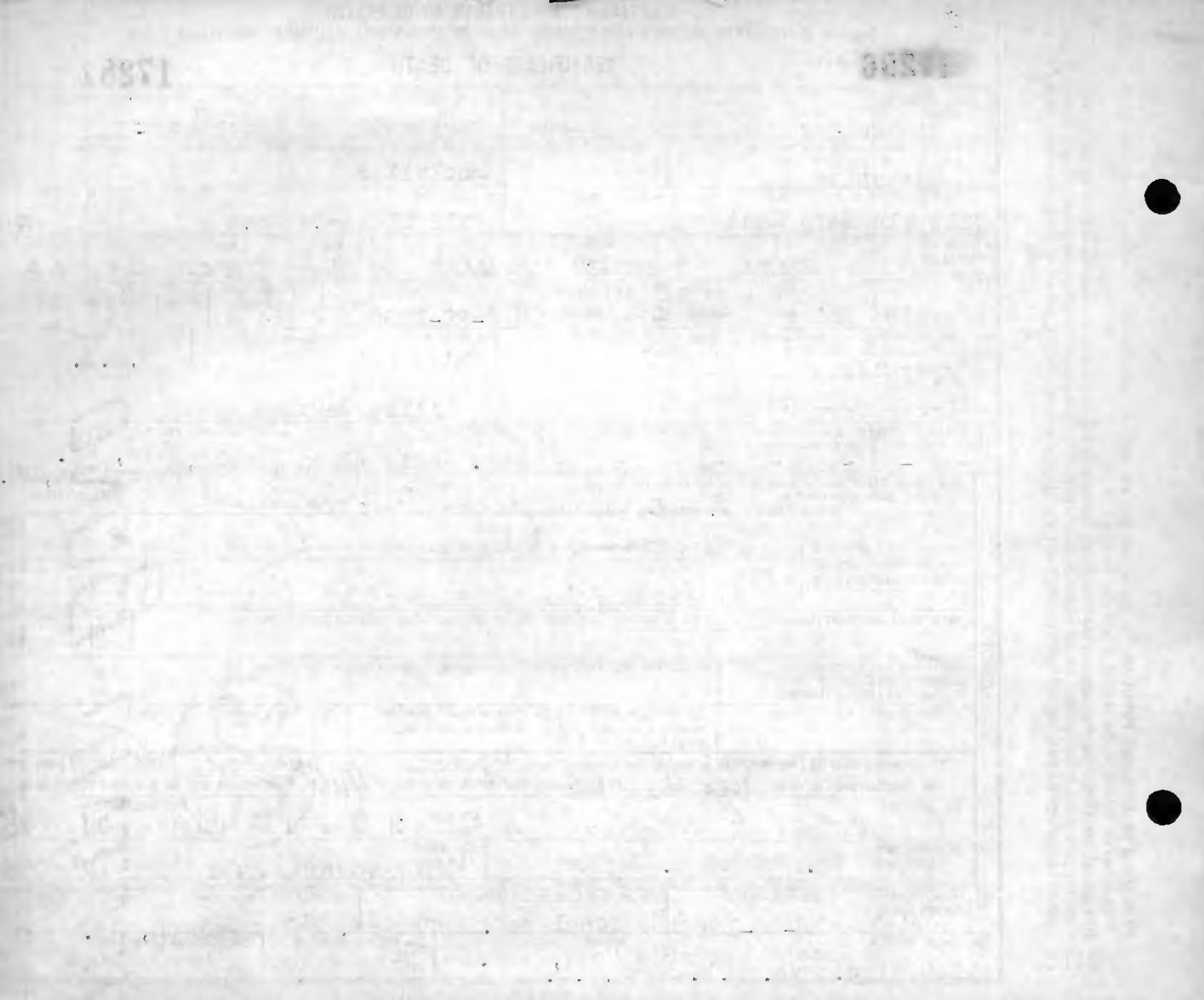
## CERTIFICATE OF DEATH

17287

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7218 Old Gate Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JULIA</b>		First <b>BERGER</b>	Middle <b>ALLEN</b>
4. DATE OF DEATH <b>DEC 21 1966</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>5-28-1882</b>	9. AGE (In years last birthday) <b>84 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>	
13. FATHER'S NAME <b>Lyman Berger</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Dawsman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Julia Allen Yowell, R.R. 1, Box 111, Rockville, Md.</b>		Address <b>7218 Old Gate, Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardio-Respiratory Failure</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost.		19. INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
(b) <b>Generalized Carcinomatosis</b> DUE TO (c) <b>Primary Adenocarcinoma Breast</b>		<b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) <b>Washington</b> (County) <b>D.C.</b> (State) <b>20015</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1965</b> to <b>Dec 1966</b> that (I) (we) last saw the deceased alive on <b>Nov 2 1966</b> and that death occurred at <b>4115 M St</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Robert G. Taylor</i>		22b. DATE SIGNED <b>Dec. 21, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert G. Taylor</b>		22d. ADDRESS <b>WASHINGTON Clinic, Wash. D.C. 20015</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-24-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>National Mem. Park Cem., Falls Church, Va.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> 5130 Wisconsin Ave. N.W. Wash.D.C.		25a. RECEIVED BY REGISTRAR <b>DEC 25 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17297

CERTIFICATE OF DEATH

17288

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, direct or page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dawsonville Rural</b>		c. LENGTH OF STAY IN lb <b>Life</b>	
d. NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street address)		c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dawsonville</b>	
		d. STREET ADDRESS <b>Rural</b>	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Russell Allnutt</b>		First <b>James</b>	Middle <b>Russell</b>
Last <b>Allnutt</b>		4. DATE OF DEATH <b>Dec. 29 1966</b>	Month Day Year
S. SEX <b>Male</b>	6. COLOR DR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 9, 1900</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	9. AGE (in years last birthday) <b>66 yrs.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Montg. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert W. Allnutt</b>		14. MOTHER'S MAIDEN NAME <b>Alice Thomas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-36-3705</b>	17. INFORMANT <b>Benoni D. Allnutt</b>
		Address <b>Poolesville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Hypertensive Cardiovascular Disease		(c) DUE TO years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Barnesville</b>
20f. (City or town) <b>Barnesville</b>		(County) <b>Montgomery</b>	(State) <b>Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>26 March 1966</b> , to <b>29 Dec. 1966</b> , that (I) (we) last saw the deceased alive on <b>28 Dec. 1966</b> , and that death occurred at <b>Barnesville</b> M. from causes and on the date stated above.		22b. DATE SIGNED <b>29 Dec 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gordon Murdoch Smith</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <b>Barnesville, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
		23b. DATE THEREOF <b>12/31/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Monocacy</b>
		23d. LOCATION (City or Town) <b>Beallsville</b>	(County) <b>Montgomery</b>
		23e. (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Constance C. Hilton Barnesville, Md.</b>		ADDRESS <b>Barnesville, Md.</b>	25a. REC'D BY REGISTRAR DATE JAN 4 1967
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

2851

STATE DEPARTMENT

TELE

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17298

## CERTIFICATE OF DEATH

17289

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
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1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN TB <i>5 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wheaton Nursing Home</i>		d. STREET ADDRESS <i>9404 Bruce Drive</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Ephraim</i>	Middle <i>J</i>	Last <i>Almquist</i>
4. DATE OF DEATH	Month <i>12</i>	Day <i>7</i>	Year <i>1966</i>
S. SEX <i>Male</i>	COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>10-23-81</i>	9. AGE (In years last birthday) <i>85 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Res. Industrial Engineer U. S. Govt.</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Ordnance</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Illinois</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>John Almquist</i>	14. MOTHER'S MAIDEN NAME <i>Caroline XXXXXXXX Petersen</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>	16. SOCIAL SECURITY NO. <i>578-32-8771</i>	17. INFORMANT <i>John R. Almquist</i>	Address <i>5413 31st St., N. W.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Acute coronary thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>	
DUE TO (b) <i>Coronary atherosclerosis</i>		Many years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>Dec. 7 1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>Dec. 7, 1966</i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1956</i> , to <i>Dec. 7</i> , 1966, that (I) (we) last saw the deceased alive on <i>Dec. 7</i> 1966, and that death occurred at <i>110A M</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Bennet A. Porter, Jr.</i>		22b. DATE SIGNED <i>Dec. 7, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Bennet A. Porter, Jr. M.D.</i>		22d. ADDRESS <i>9301 Colesville Rd., Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Dec. 9, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co., Md.</i>
24. FUNERAL DIRECTOR <i>Clark E. Winsor</i>	ADDRESS <i>8434 Georgia Ave.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE
VR A15 (4) 20 M 1/66	DATE <i>DEC 14 1966</i>		

19571

80000

Items 16&21 Film 352-1 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

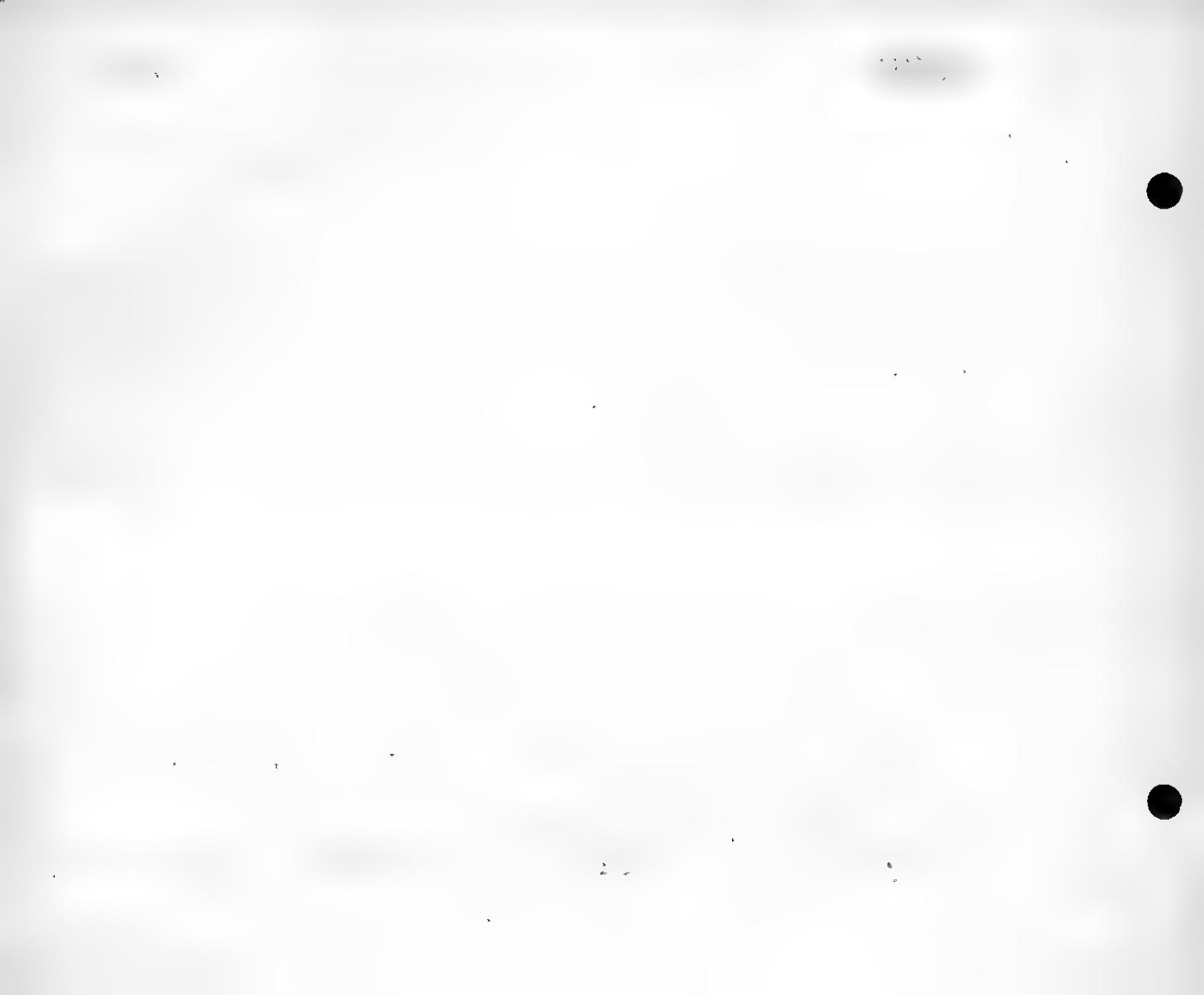
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in an event within 72 hours after death.

17289

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17290

1. PLACE OF DEATH a. COUNTY <i>Newcomer</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	c. LENGTH OF STAY IN b <i>30 hrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	d. COUNTY <i>Montgomery</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>CHARLES</i>	Middle <i>H. Anderson Jr.</i>	Last 4. DATE OF DEATH <i>DECEMBER 7 1966</i>
S. SEX <i>m</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
10a. OCCUPATION (Give kind of work done during most of working life even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Plumber</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address 7713 Greenwood Ave., Takoma Park</i>	
13. FATHER'S NAME <i>Charles H. Anderson Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Margaret M. Tolay</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>yes. W.W. #1</i>		16. SOCIAL SECURITY NO. <i>17. INFORMANT Alfred Anderson As Executor</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Diabetic acidosis secondary to</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Diabetes mellitus; Multiple pulmonary</i> DUE TO (c) <i>emboli and pneumonia</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Rap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, Room No., or county) <i>Arlington National Cemetery, Arlington, Virginia</i>	
22. DATE SIGNED <i>Dec. 7, 1966</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE THEREOF <i>Dec 12-1966</i>	23c. NAME OF CEMETERY OR CRYPTORY <i>Arlington National Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Washington</i>
24. FUNERAL DIRECTOR <i>Arthur Walters</i>	254. ADDRESS <i>7713 Greenwood Ave.</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 14 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17300

## CERTIFICATE OF DEATH

17291

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		c. LENGTH OF STAY IN TB <i>29 days</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>Maryland</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		e. STREET ADDRESS <i>4105 Lynd Court</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Frank Oscar Anderson</i>		First	Middle	Last	4. DATE OF DEATH <i>12 10 1966</i>	Month	Day	Year
S SEX <i>Male</i>	6 COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 10x-1876</i>	9. AGE (In years last birthday) <i>90 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Insurance Agent</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>		11. BIRTHPLACE (County & State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Gustolph Anderson</i>		14. MOTHER'S MAIDEN NAME <i>Anna Goldburg</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <i>No None</i>		16. SOCIAL SECURITY NO <i>818541585</i>		17. INFORMANT <i>Frank O. Anderson</i>		Address <i>home at above #2</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>1 Month</i>						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>471A</i>		DUE TO <i>Bronchopneumonia</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i>		DUE TO <i></i>						
(c) <i></i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis Severe Generalized.</i>							19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>11-1, 1966</i> to <i>12-10, 1966</i> , that (II) (we) last saw the deceased alive on <i>12-9, 1966</i> , and that death occurred at <i>Georgia M.</i> from causes and on the date stated above.								
22a. SIGNATURE <i>Edward J. Richards</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12-10-66</i>				
22c. PHYSICIAN'S NAME (Type) <i>Edward J. Richards</i>		22d. ADDRESS <i>10110 Georgia Ave. S.S. Md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>December 13, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co., Md</i>		
24. FUNERAL DIRECTOR <i>John B. Thomas</i> <i>Harrar E. Murphy, Inc.</i>		ADDRESS <i>48434 Georgia Ave.</i>		25a. REC'D BY REGISTRAR <i>DEC 14 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Judge</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17301

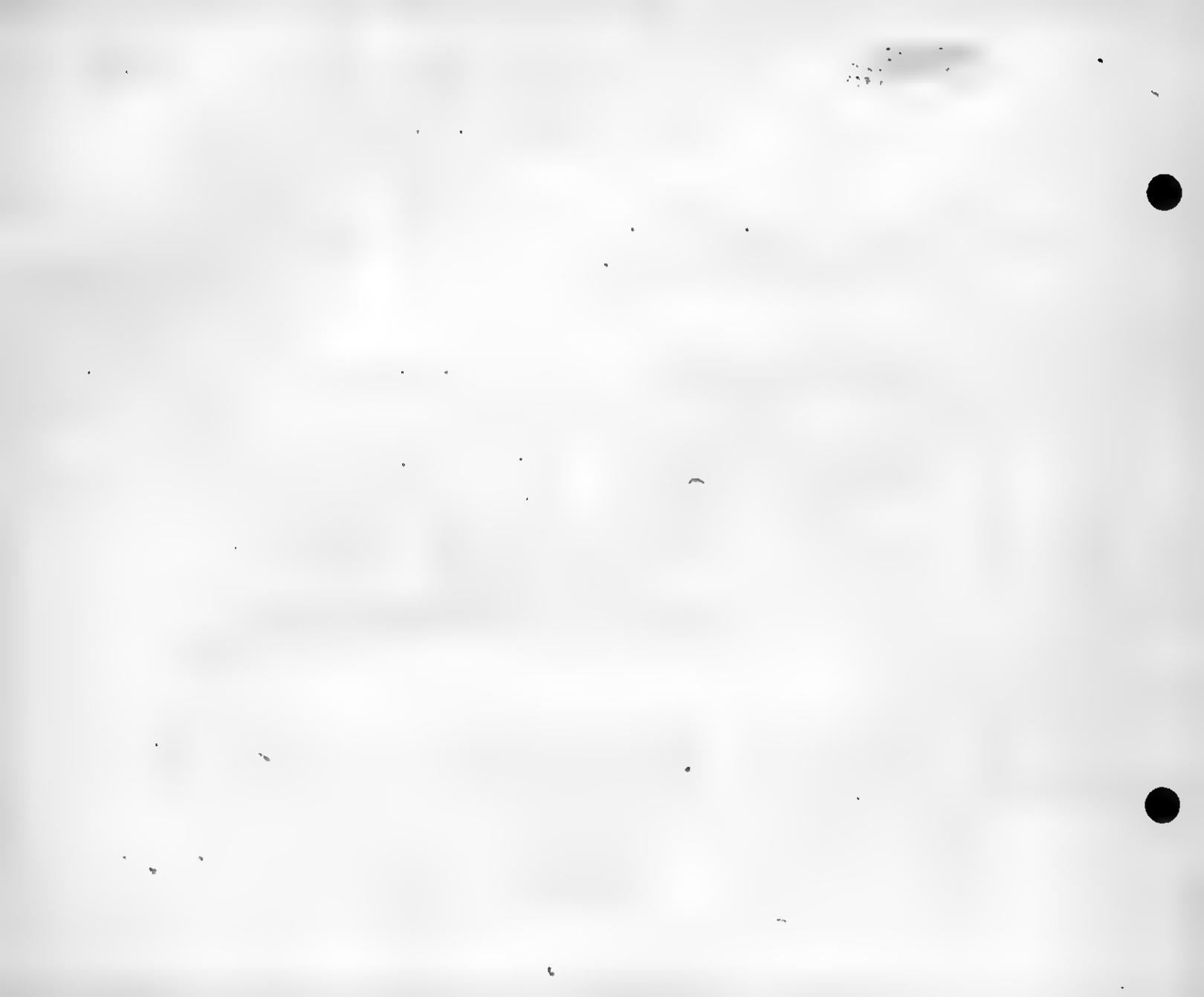
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17292

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived if institution Residenc before admission) a. STATE <b>W.Va.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c LENGTH OF STAY IN 1b MARYLAND	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Washington San. &amp; Hosp.</b>		e STREET ADDRESS <b>400 Murray Ave.</b>	
f FIRST <b>REESE</b>		g MIDDLE <b>ELMER</b>	
h LAST <b>ANDERSON</b>		i DATE OF DEATH 12 -- 27 1966	
j SEX <b>Male</b>		k COLOR OR RACE <b>White</b>	
l MARRIED <b>X</b>		m NEVER MARRIED <input type="checkbox"/>	
n WIDOWED <input type="checkbox"/>		o DIVORCED <input type="checkbox"/>	
p. DATE OF BIRTH <b>6-16-00</b>		q AGE (in years last birthday) <b>66 yrs</b>	
r. KIND OF BUSINESS OR INDUSTRY <b>Retired B.R. Engin. Bro. S.H.</b>		s. F UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
t. BIRTHPLACE (State or foreign country) <b>W.Va.</b>		u. F UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
v. FATHER'S NAME <b>Anderson</b>		w. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>	
x. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		y. SOC. A. SECURITY NO <b>WW 1 Marines 193-10-8895 Mrs. Ola Anderson - Wife</b>	
z. INFORMANT <b>Gatewood</b> Address			
aa. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: MMED AT CAUSE (a) <b>410.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		bb. DUE TO (b) <b>Acute Coronary Insufficiency</b> Due to (c) <b>Coronary Artery Heart Disease</b> Due to (c) <b>Essential Hypertension</b>	
cc. INTERVAL BETWEEN ONSET AND DEATH			
dd. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		ee. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ff. MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		gg. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
hh. 20c. TIME OF INJRY Month, Day, Year Hour o.m. p.m. <b>19</b>		ii. 20d. INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
jj. 20e. PLACE OF INJRY (Home, farm factory, street office bldg etc)		kk. 20f. (City or town) <b>Fairmont</b> (County) <b>West Virginia</b> (State)	
ll. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		mm. 22. DATE SIGNED <b>12/27/1966</b>	
nn. ACTUAL SIGNATURE <b>Belden R. Pappin, M.D.</b>		oo. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or county) <b>1755 &amp; Wisconsin Ave Bethesda, Md</b>	
pp. 23a. BURIAL, CREMATION, BURIAL <input type="checkbox"/> Cremation <input type="checkbox"/>		qq. 23b. DATE THEREOF <b>12-30-66</b>	
rr. 23c. NAME OF CEMETERY OR CREMATORIUM <b>Woodsdale Cemetery</b>		ss. 23d. LOCATION (City or Town) <b>Fairmont</b> (County) <b>West Virginia</b> (State)	
tt. 24. FUNERAL DIRECTOR <b>Robert A PUMPHREY</b>		uu. 25a. REC'D. BY REGISTRAR DATE <b>DEC 30 1966</b>	
vv. 25b. REGISTRAR'S SIGNATURE <b>James J. Edge</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

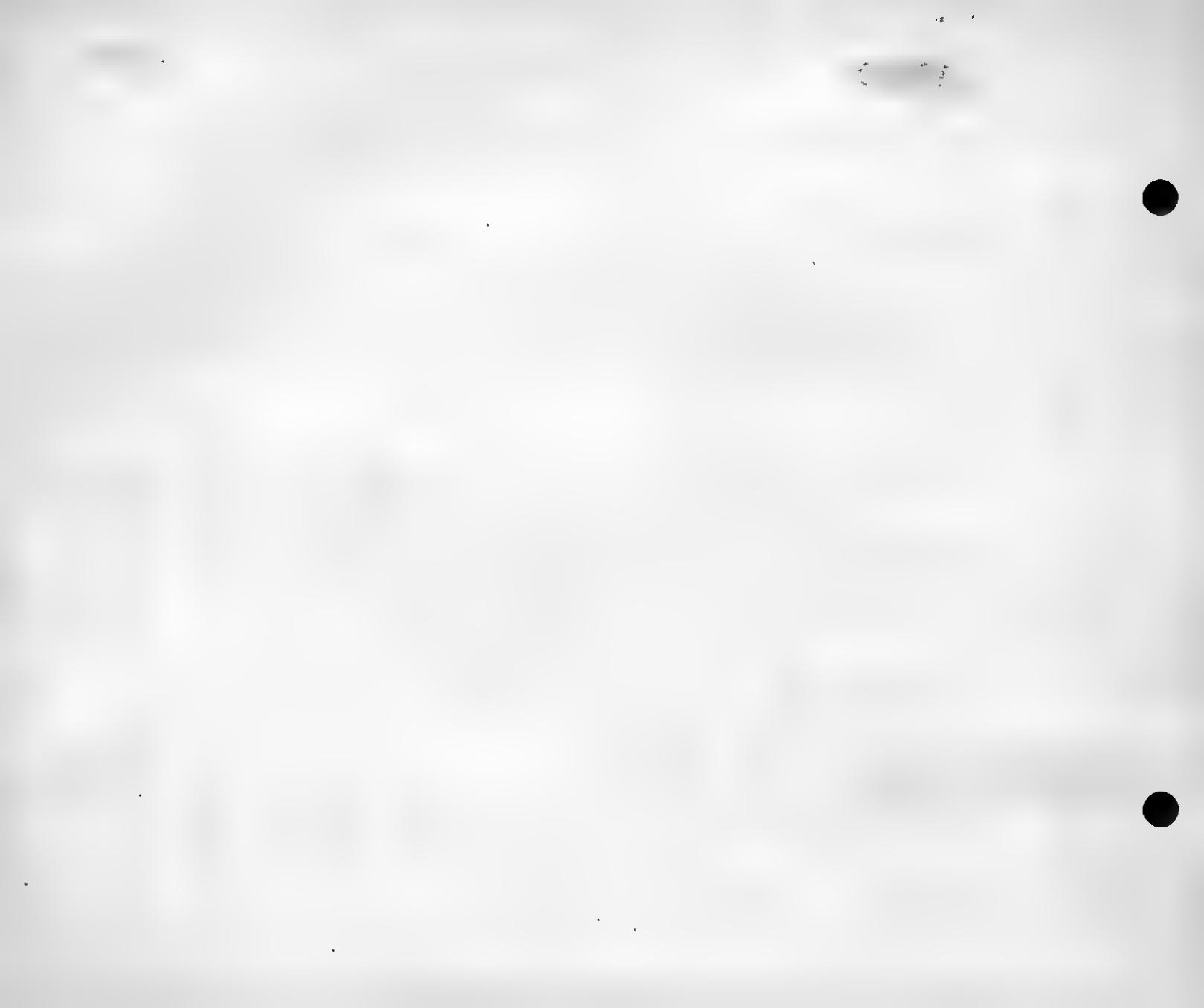
## CERTIFICATE OF DEATH

17293

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>3 yrs 5 mos</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Washington</i>		b. COUNTY <i>D. C.</i>										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Congressional Manor</i>		e. STREET ADDRESS <i>871212 Gallatin St. N.W.</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <i>J. CLYDE ARMSTRONG</i>		First	Middle	Last	4. DATE OF DEATH <i>Dec 31 1966</i>	Month	Year	5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-24-1884</i>	9. AGE (In years lost birthday) <i>82 yrs.</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS Days <i>16</i>	Hours <i>45</i>	Min. <i>1966</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Kansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>												
13. FATHER'S NAME <i>Edw. R. Armstrong</i>		14. MOTHER'S MAIDEN NAME <i>Nannie E. Hull</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Nursing Home records</i>		Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Myocardial Failure</i>		DUE TO <i>4000</i>		DUE TO <i>Branchial asthma + Emphysema</i>		DUE TO <i>Arteriosclerosis, generalized</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost</i>																		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)										
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20g. DATE OF DEATH <i>9/15 1965</i>		20h. DATE OF DEATH <i>12/1 1966</i>		20i. (City or town) (County) (State)												
21. I certify that (I) (this hospital) attended the deceased from <i>9/15 1965</i> to <i>12/1 1966</i> , that (I) (we) last saw the deceased alive on <i>11/28 1966</i> , and that death occurred at <i>3304 M.</i> from causes and on the date stated above.		22a. SIGNATURE <i>John E. Everett</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <i>John E. EVERETT</i>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/1/66</i>										
22c. PHYSICIAN'S NAME (Type) <i>John E. EVERETT</i>		22d. ADDRESS <i>9400 Conn. Ave Kensington</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Funeral</i>		23b. DATE THEREOF <i>12/3/1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Thornrose Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Steverton, Virginia</i>								
24. FUNERAL DIRECTOR <i>Northwell Caskets Inc. 294 Carroll Street, N.W.</i>		ADDRESS <i>Washington, D.C. 20008</i>		25a. REC'D BY REGISTRAR <i>DEC 5 1966</i>		25b. REGISTRAR'S SIGNATURE <i>James C. Judge</i>												
VR A15 (4) 20 M 1/66																		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17303

## CERTIFICATE OF DEATH

17294

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC VALLEY NURS. HOME</u>				d. STREET ADDRESS <u>50 Irving St. N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <u>Leah</u>		First	Middle	Last	4 DATE OF DEATH <u>Atthey Dec. 11 1966</u>
5. SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>8-8-84</u>	9 AGE (In years last birthday) <u>82 yrs.</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>—</u>		11) BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u>	
13. FATHER'S NAME <u>ISAAC FIDDESON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <u>Yes. WWII</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>SADIE D. PRATSHON</u> Address <u>8117 LARONA DR.</u> <u>SILVER SPRING, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> INTERVAL BETWEEN DUE TO <u>Stroke</u> ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a) <u>Coronary Thrombosis</u> 1 week stating the underlying cause (b) <u>Coronary Thrombosis</u> <u>Stroke</u> lost <u>—</u> (c) <u>Coronary Thrombosis</u> <u>Stroke</u>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Synd., etc. N.Y.T.</u>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>
21. I certify that (I) (this hospital) attended the deceased from <u>3/14/1966</u> , to <u>12/14/1966</u> that (I) (we) last saw the deceased alive on <u>12/10/1966</u> and that death occurred at <u>8:00 AM</u> , from causes and on the date stated above.					
22a SIGNATURE <u>Stephen Jones</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>12/11/66</u>		
22c PHYSICIAN'S NAME (Type) <u>STEPHEN JONES</u>		22d. ADDRESS <u>809 Vicks Mill Rd, Rockville, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>12-14-66</u>	23c NAME OF CEMETERY OR CREMATORIAL <u>Washington Nat'l Cem.</u>		23d LOCATION (City or Town) <u>Arlington</u> (County) <u>VA.</u> (State) <u>—</u>
24 FUNERAL DIRECTOR <u>GODFREY FUNERAL HOME</u>		ADDRESS <u>4217 9th St. N.W.</u>	25a. REC'D BY REGISTRAR DATE <u>DEC 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17304

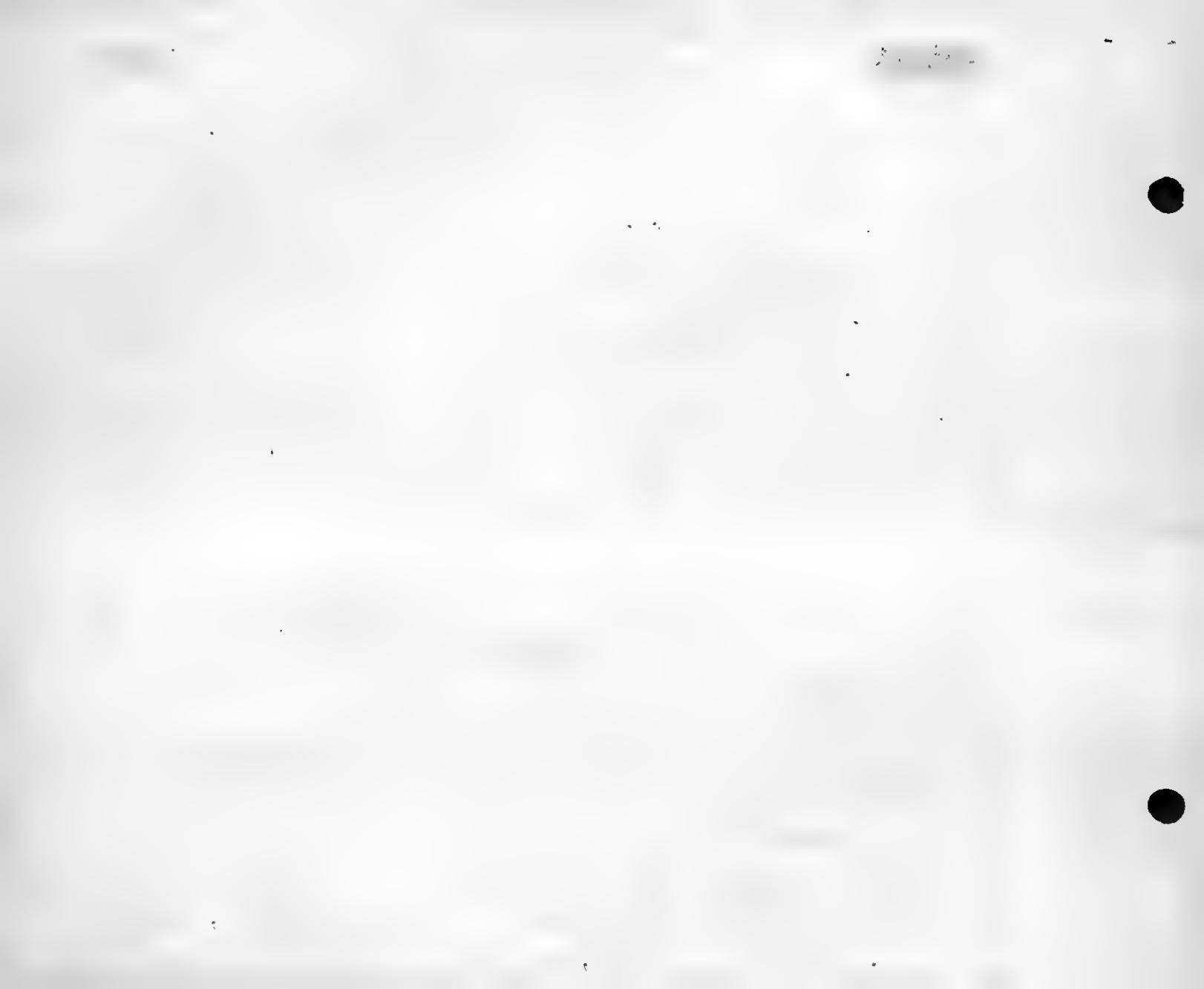
CERTIFICATE OF DEATH

17295

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> D.O.A.		c. LENGTH OF STAY IN 1b <u>8015 Glenbrook Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8015 Glenbrook Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jessie E. Ayers</u>		4. DATE OF DEATH Last <u>DEC. 6</u>	Month <u>1966</u>
5. SEX <u>F. white</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <u>April 23 1881</u>		9. AGE (In years last birthday) <u>80 yrs</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Croucher</u>		14. MOTHER'S MAIDEN NAME <u>Julia Shelton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>578 29 2493</u>	
17. INFORMANT <u>Charles J. Ayers Jr.</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Art. Cardiovascular Disease</u> DUE TO (c) <u>&amp; Congestive Heart Failure</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Pulmonary Emphysema, Diabetes Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>WASH. D.C. CLINIC</u>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>1966</u> , that (I) (we) last saw the deceased alive on <u>12-5 1966</u> , and that death occurred at <u>4:02 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. Youngblood</u>		22b. DATE SIGNED <u>12/16/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD W. YOUNGBLOOD</u>		22d. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-9-66</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Cedar Hill Cemetery</u>
23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		ADDRESS <u></u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>
		DATE <u>DEC 9 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**17305**

**CERTIFICATE OF DEATH**

**17296**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>D.O.A.</i>		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash San + Hospital</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelphi</i>	
d. STREET ADDRESS <i>1923 Ruatan St</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Car</i>		First <i>Clive</i>	Middle <i>Ballard</i>	Last <i>Lula</i>	4. DATE OF DEATH Month <i>12</i> Day <i>10</i> Year <i>1966</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>1-14-12</i>	9. AGE (In years less birthday) <i>54</i> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Design Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Naval Ordnance</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Silvertown, Ohio</i>	
13. FATHER'S NAME <i>William J. Ballard</i>		14. MOTHER'S MAIDEN NAME <i>Lula Fugent</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> None		16. SOCIAL SECURITY NO <i>269-09-8622</i>		17. INFORMANT <i>Adelaide Ballard</i> Address <i>1923 Ruatan St.</i> <del>XXXXXX</del> Adelphi, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4201</i>		DUE TO (b) <i></i>		Myocardial infarction	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i></i>		DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i></i>	(County) <i></i> (State) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>9-28, 1966</i> , to <i>12-10, 1966</i> , that (I) (we) last saw the deceased alive on <i>12-8 1966</i> , and that death occurred at <i>10:30 PM</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>Eino Magi</i>		M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED <i>12-10-1966</i>		
22c. PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>		22d. ADDRESS <i>831 University Blvd. E., Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Dec. 13, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Crematory</i>	23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co., Md.</i>	
24. FUNERAL DIRECTOR <i>John B. Thomas Warren E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>	25a. REC'D BY REGISTRAR <i>DEC 11 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**TO HOSPITAL** ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17306

## CERTIFICATE OF DEATH

17297

1. PLACE OF DEATH  
a. COUNTY

Montgomery

MARYLAND

LENGTH OF STAY IN lb

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

BETHESDA

2 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

5604 RIDGEFIELD Rd.

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Anne W

Berthe

## 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

e. STATE

b. COUNTY

Montgomery

Md.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

d. STREET ADDRESS

5604 Ridgefield Rd

e. IS RESIDENCE  
ON A FARM?  
YES  NO 

## 5. SEX

F

6. COLOR OR RACE

WIDOWED

7. MARRIED  NEVER MARRIED DIVORCED 

8. DATE OF BIRTH

9-26-85

Last

Month

Day

Year

12 - 7 - 1966

IF UNDER 1 YEAR Months Days Hours Min.

IF UNDER 24 HRS.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

at home

## 10b. KIND OF BUSINESS OR INDUSTRY

—

## 11. BIRTHPL.ACE (County &amp; State, or foreign country)

N.J.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Theobaut Ober

## 14. MOTHER'S MAIDEN NAME

Anna Hechinger

Address 56104 Ridgefield Rd

Bethesda, Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  16. SOC AL SECURITY NO.

(Yes, no, or unknown) (If yes, give rank and dates of service)

No

## 17. INFORMANT

139-10-5013-D Mrs Robert R. Schaeff

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Acute myocardial infarction 7 days

Generalized cardiovascular arteriosclerosis 10 years

## MEDICAL CERTIFICATION

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not While  
Hour e.m. p.m. 19 at work  at work   
factory, street, office bldg., etc

20f. (City or town) (County) (State)

21. I certify that (I) (This Hospital) attended the deceased from January 1965 to December 6, 1966 that (I) (we) last saw the deceased alive on December 6, 1966, and that death occurred at 6 PM, from the causes and on the date stated above

## 22a. SIGNATURE

C. Roger Kuntz, M.D.

22b. DATE SIGNED  
12-7-66

22c. PHYSICIAN'S NAME (Type) C. Roger Kuntz, M.D. 3701 Connecticut Ave. N.W. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county) (State)

Removal 12-8-66 Fairmount Cemetery Newark N.J.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS West, D.C. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Joseph Gowler's Sons 5130 Wisconsin Ave., N.W. DATE DEC 14 1966 Charles Judge



Items 18-21 Film G372 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

FOR STATE  
HEALTH DEPT.

16516

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH

COUNTY

*Montgomery*

MARYLAND

2. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

*Silver Spring*

C. LENGTH OF STAY IN 1B

*9½ years*

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

*10207 Tenbrook Drive*

3. NAME OF  
DECEASED  
(Type or print)

First  
*CHARLES*

Middle  
*L. en*

Last  
*BEACH*

4. DATE  
OF  
DEATH

Month  
*DEC.*

Day  
*12*

Year  
*1965*

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

*July 6, 1913*

9. AGE (In years  
last birthday)

*52 yrs.*

10. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

*Washington, D. C.*

12. CITIZEN OF WHAT  
COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Joe Lockwood Reech*

14. MOTHER'S MAIDEN NAME

*Daisy Ann Wallandingham*

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown)  (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

*577-10-3825*

17. INFORMANT

*Mary B. Williams*

Address  
*10207 Tenbrook Drive*

*Silver Spring, Maryland*

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) *Acute asphyxiation due to aspiration of*

INTERVAL BETWEEN  
ONSET AND DEATH

10-10  
DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) *gastric contents accompanied by myocardial*

DUE TO

(c) *insufficiency.*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

*Deceased ~~reached~~ vomited and ~~then~~ aspirated gastric*

20c. TIME OF INJURY Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour a.m.  
*5:00 am.*

White  Not White

at work  at work

factory, street, office bldg., etc.)

Home

Silver Spring Montg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion

death resulted from: Natural causes  Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

CHIEF MEDICAL EXAMINER   
ASSISTANT MEDICAL EXAMINER   
DEPUTY MEDICAL EXAMINER   
Address (Street, city, town, or county)  
*Belden R. Reap, M.D. Wheaton*

22. DATE SIGNED

*Dec. 13, 1965*

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

*Dec. 15, 1965*

23c. NAME OF CEMETERY OR CREMATORIUM

*Cedar Hill Cemetery*

23d. LOCATION (City, town or county) (State)

*Wheaton, Maryland*

24. FUNERAL DIRECTOR

ADDRESS

*8434 Georgia Avenue*

*Warren E. Humphrey, Inc.*

*Silver Spring, Md.*

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

*Charles Judge*

DATE DEC 17 1965

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3 Page 5 may be retained for your files.

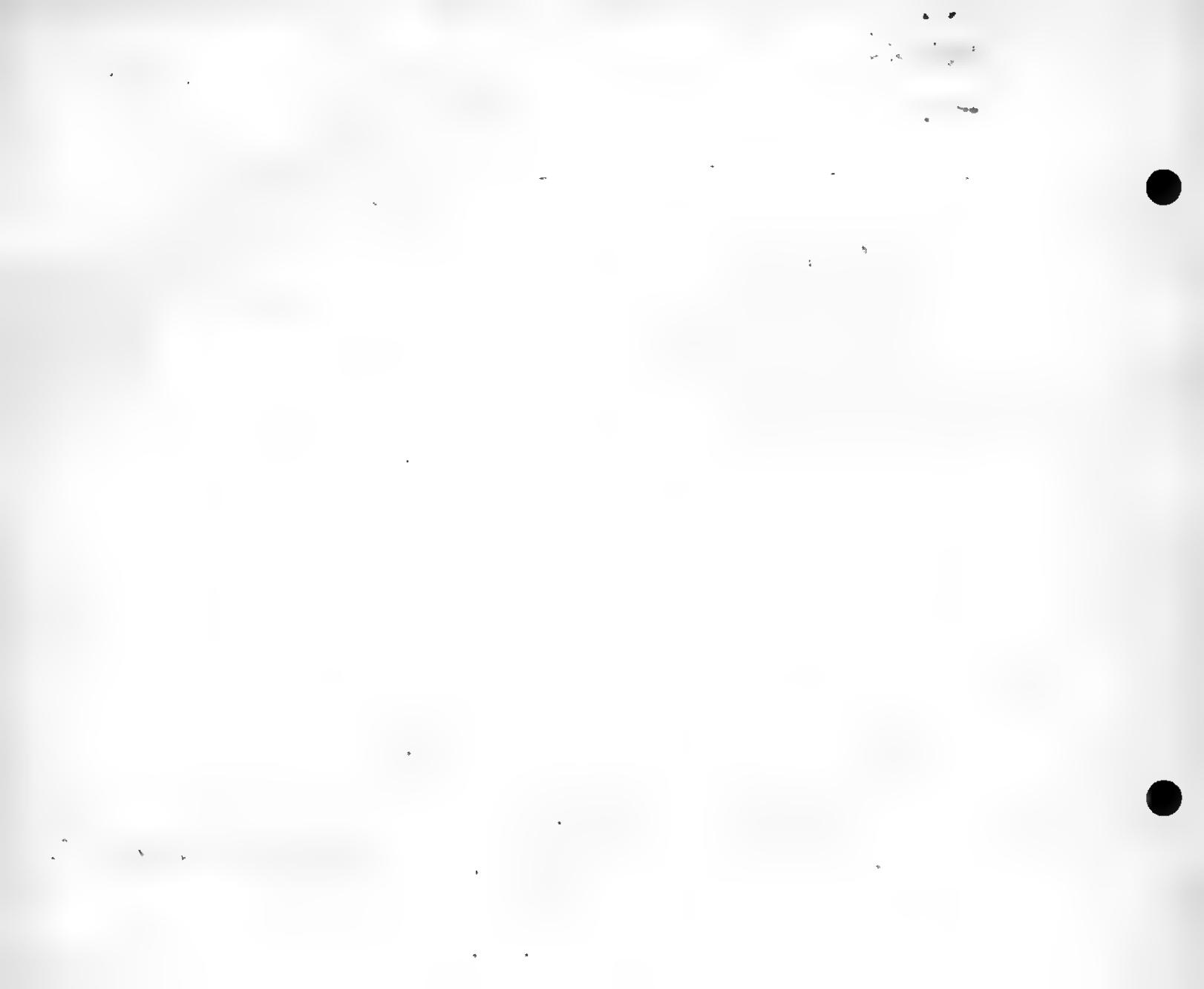
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1, 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return to me within 72 hours after death.

17307

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17298

1 PLACE OF DEATH <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) <i>Maryland</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c LENGTH OF STAY IN 1b <i>6 hrs.</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Damascus</i>	
3 NAME OF DECEASED (Type or print) <i>ETHEL H. BEASLEY</i>		First	Middle
		Lost	4 DATE OF DEATH <i>DEC. 14 1966</i>
5 SEX <i>Fe</i>	6 COLOR OR RACE <i>Cauc</i>	7 MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED
10a SOCIAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <i>Oregon</i>		9 AGE (In years last birthday) <i>76 yrs</i>	
13. FATHER'S NAME <i>Francis Sprague</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17 INFORMANT <i>Richard J. Beasley, Item 2</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute, severe, intracranial injury with</i> <i>816.4</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>hemorrhage incurred in auto accident</i> (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Deceased was front seat passenger in auto which collided, head-on, with another car.</i>	
20c TIME OF INJURY Month, Day, Year <i>250 Hour 12-13 1966 pm</i>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street</i>
		20f (City or town) <i>Damascus</i>	(County) <i>Montgomery</i>
		(State) <i>Md.</i>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER EXAMINER'S NAME (Type) <i>BELDEN R. KEMP M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, County or county) <i>1325 N. Charles St., Baltimore, Md.</i>	22. DATE SIGNED <i>Dec. 14, 1966</i>
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE THEREOF <i>Dec. 16, 1966</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Pine Grove</i>	23d LOCATION (City or Town) (County) (State) <i>Mt. Airy, Md.</i>
24 FUNERAL DIRECTOR <i>Ellis L. Materni</i>	ADDRESS <i>Damascus, Md.</i>	25a REC'D BY REGISTRAR DATE <i>DEC 19 1966</i>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17299

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>8005-EASTERN AVE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>			d. STREET ADDRESS <b>SILVER SPRING MD</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>CHARLES</b>	Middle	Last <b>H. Becker</b>	4. DATE OF DEATH Month <b>12</b> Day <b>13</b> Year <b>1966</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>CHAU</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/13/02</b>	9. AGE (In years last birthday) <b>64 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>INSURANCE BROKER INSURANCE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>
13. FATHER'S NAME <b>Samuel Becker</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT WIFE <b>EUGGIE C. BECKER - 8005-EASTERN AVE</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4260</b>			DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute laryngitis</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 11, 1966</b> , to <b>Dec 12, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 12, 1966</b> , and that death occurred at <b>12:30 PM</b> , from causes and on the date stated above					
22a. SIGNATURE <b>Blaine Efig</b>			22b. DATE SIGNED <b>Dec 12, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Blaine Efig, M.D.</b>			22d. ADDRESS <b>8641 Coleridge Rd Silver Spring Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-14-66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>KING-DAVID MEMORIAL GARDEN - FALLS CHH - VA</b>	23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>B. DANZANSKY &amp; SONS - WASHINGTON DC</b>		ADDRESS <b>1100 19th Street N.W. Washington D.C.</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>

21  
20 20



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17309

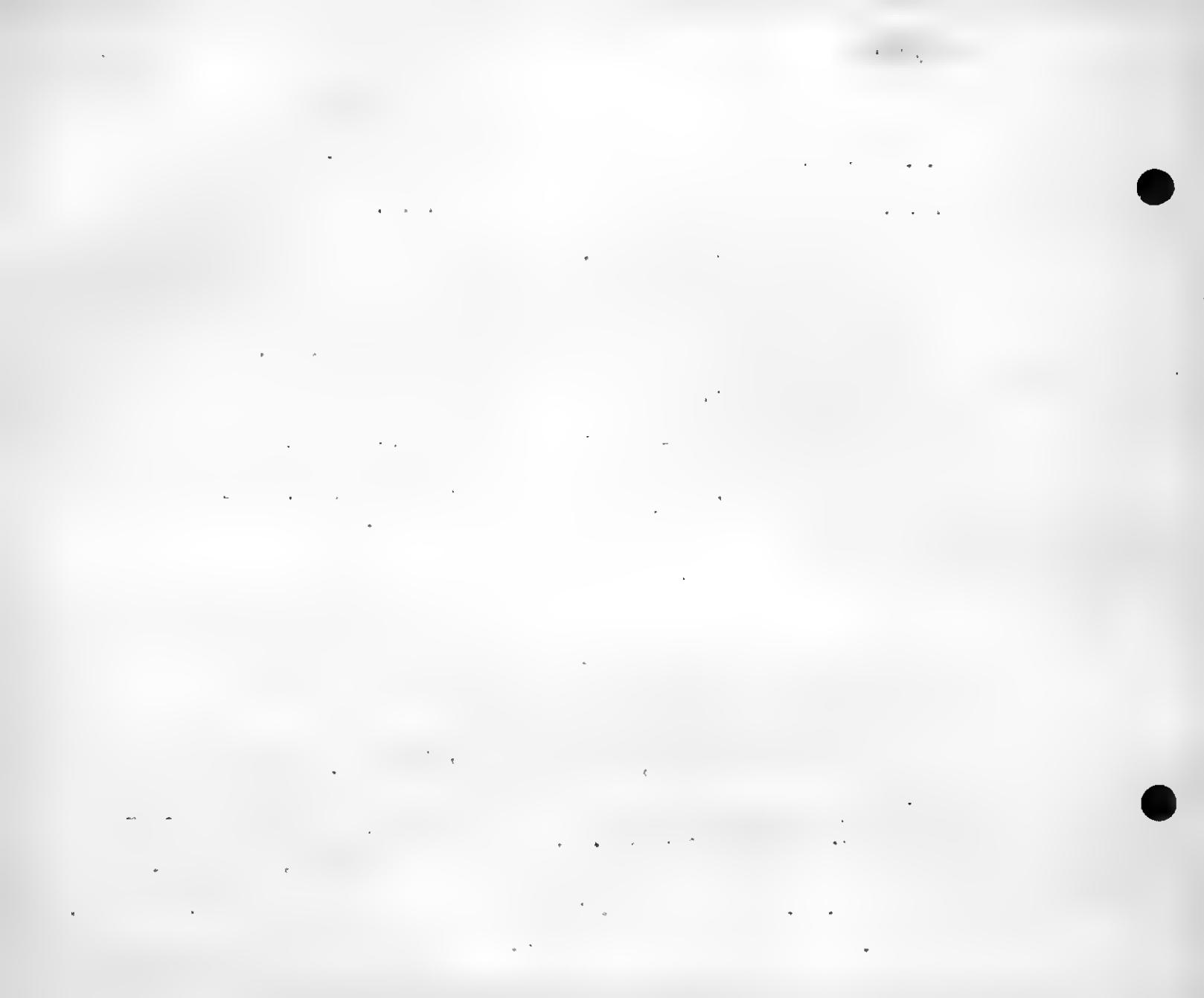
CERTIFICATE OF DEATH

17300

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
a. COUNTY		a. STATE Maryland b. COUNTY Montgomery									
Montgomery		Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Rural - Levisdale				Rural - Lewisdale							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS									
R.F.D. # 1, Monrovia		R.F.D. # 1, Monrovia									
e. IS RESIDENCE ON A FARM?											
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
		Margaret	T.	Beetz	Dec. 19			1966			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF OVER 24 HRS				
Female		White	WIOOWEO <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	April 2, 1880	86 yrs.	Months	Days	Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife								Libertytown, Md.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Edward E. Doherty		Mary Byrne									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		219-54-2357		Mrs Frances Keith, Item 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced Arteriosclerotic Cardio-vascular-renal <i>441.2X</i>											
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c) DUE TO Disease with Hypertension.										10 years?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No Injury									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from May 8, 1951 19 to December 19 1966, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on December 19, 1966, and that death occurred at 10A M, from the causes and on the date stated above.											
22a. SIGNATURE <i>E. McKendree Boyer, M. D.</i>		22b. DATE SIGNED 12-20-66									
22c. PHYSICIAN'S M. McKendree Boyer, M. D. NAME (Type)		22d. ADDRESS 9701 Church Street Damascus, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 22, 1966		23c. NAME OF CEMETERY OR CREMATORIUM St. Michael's		23d. LOCATION (city, town or county) (State) Poplar Springs, Md.					
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		ADDRESS		25a. REC'D BY REGISTRAR DEC 23 1966		25b. REGISTRAR'S SIGNATURE <i>J. L. Molesworth</i>					



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17310

## CERTIFICATE OF DEATH

17301

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		< LENGTH OF STAY IN lb <b>48 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9304 Warren Street</b>				d. STREET ADDRESS <b>9304 Warren Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <b>Frances</b>	Middle <b>B.</b>	4. DATE OF DEATH <b>Benedict</b>	Month <b>December</b>	Day <b>13</b>	Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1888</b>	9. AGE (In years last birthday) <b>78</b> yrs	10. IF UNDER 1 YEAR Months <b>0</b>	Days <b>0</b>	IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		
13. FATHER'S NAME <b>Joseph Burkett</b>			14. MOTHER'S MAIDEN NAME <b>Frances Reese</b>			12. CITIZEN OF WHAT COUNTRY? <b>A. S. A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO <b>yes</b>		17. INFORMANT <b>James E. Benedict, Jr. Silver Spring, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 13, 1966</b> , to <b>Dec. 13, 1966</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>10:55 AM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>Bennet A. Porter, Jr.</b>							
22b. DATE SIGNED <b>December 13, 1966</b>							
22c. PHYSICIAN'S NAME (Type) <b>Bennet A. Porter, Jr., M.D.</b>		22d. ADDRESS <b>9301 Colesville Rd., Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Dec. 15, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Md.</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas</b>		ADDRESS <b>8434 Georgia Ave</b>		25a. REC'D BY REGISTRAR <b>DEC 20 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Judge</b>	
20 M 1/66		Warren E. Lumpkin, Inc.		Silver Spring, Md.			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17311		17302		
<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>9 HRS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>		<b>2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)</b> a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>4503 Gridley Rd.</b>		
<b>3. NAME OF DECEASED</b> <b>Paul</b> First <b>Eugene</b> Middle <b>Billard, Jr.</b> <small>(Type or print)</small>		<b>4. DATE OF DEATH</b> <b>Dec 24 1966</b>		
<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		<b>8. DATE OF BIRTH</b> <b>12/23/166</b> <b>9. AGE (in years lost birthday) yrs</b> <b>9</b>		
<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <b>Bethesda Maryland</b>		
<b>13. FATHER'S NAME</b> <b>Paul Eugene Billard, Sr.</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Lillian E. Grapes</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Paul E. Billard, Sr.</b> <b>Address</b> <b>4503 Gridley Rd.</b> <b>Silver Spring, Md.</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. (a) <b>76d.5</b> <b>IMMEDIATE CAUSE (a)</b> <b>1moxia</b> <small>DUE TO</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</small> (b) <b>Atherosclerosis</b> <small>DUE TO</small> <small>Premature death.</small> (c)		<small>INTERVAL BETWEEN ONSET AND DEATH</small>		
<b>19. MEDICAL CERTIFICATION</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year <small>Hour o.m.</small> <b>p.m.</b> <b>19</b>		20d. INJURY OCCURRED <small>While at work</small> <input type="checkbox"/> <small>Not While at work</small> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>410A M</b>	20f. (City or town) <b>(County)</b> <b>(State)</b>
21. I certify that (I) (this hospital) attended the deceased from <b>12-23-66</b> , to <b>12-24-66</b> , that (I) (we) last saw the deceased alive on <b>12-24-66</b> , and that death occurred at <b>410A M</b> , from causes and on the date stated above.		<b>22b. DATE SIGNED</b>		
22a. SIGNATURE <b>Michael L. Buckley</b>		M.D. <input type="checkbox"/> ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>Michael L. Buckley</b>		22d. ADDRESS <b>9412 Old Georgetown Rd., Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 30, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cemetery</b>	23d. LOCATION (City or Town) <b>Silver Spring, Maryland</b> <small>(County) (State)</small>
24. FUNERAL DIRECTOR <b>Clark E. Wiser</b> <small>(Last, first, middle)</small> <b>Warren E. Humphrey, Inc.</b>		ADDRESS <b>34 Georgia Ave.</b>	25a. REC'D. BY REGISTRAR <b>JAN 3 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17312

CERTIFICATE OF DEATH

17303

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <b>Maryland</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		b COUNTY <b>Montgomery</b>	
c LENGTH OF STAY IN 1b <b>24 hours</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		d STREET ADDRESS <b>8817 Glenville Road Apt. 1</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <b>Freda</b>	Middle <b>(NMN)</b>	4 DATE OF DEATH Month <b>December</b> Month <b>12</b> Day <b>1966</b>
5 SEX <b>female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>July 23, 1906</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b KIND OF BUSINESS OR INDUSTRY <b>own home</b>	9 AGE (In years last birthday) <b>60</b> yrs	
13 FATHER'S NAME <b>John MAYER</b>	14 MOTHER'S MAIDEN NAME <b>MARIE Kliendienst</b>	10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>No</b>	16 SOCIAL SECURITY NO <b>033-12-6721</b>	17 INFORMANT <b>Francis J. Birmingham</b>	Address <b>8817 Glenville Rd., Silver Spring, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral Hemorrhage, Acute</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO <b>General atherosclerosis</b> years			
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>July 1959</b> to <b>12-17</b> , 1966, that (I) (we) last saw the deceased alive on <b>12-11</b> , 1966, and that death occurred at <b>5:35 AM</b> , from causes and on the date stated above.			
22a SIGNATURE 		22b DATE SIGNED <b>12-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT B. IREY</b>	22d ADDRESS <b>7105 Riggs Rd. Hyattsville, Md.</b>		
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>Dec. 15, 1966</b>	23c NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Md.</b>
24 FUNERAL DIRECTOR <b>John B. Thomas</b>	ADDRESS <b>John B. Thomas, 8134 Georgia Ave.</b>	25a REC'D BY REGISTRAR <b>Charles Judge</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>
25a REC'D BY REGISTRAR <b>Charles Judge</b>	DATE DEC 16 1966		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17313

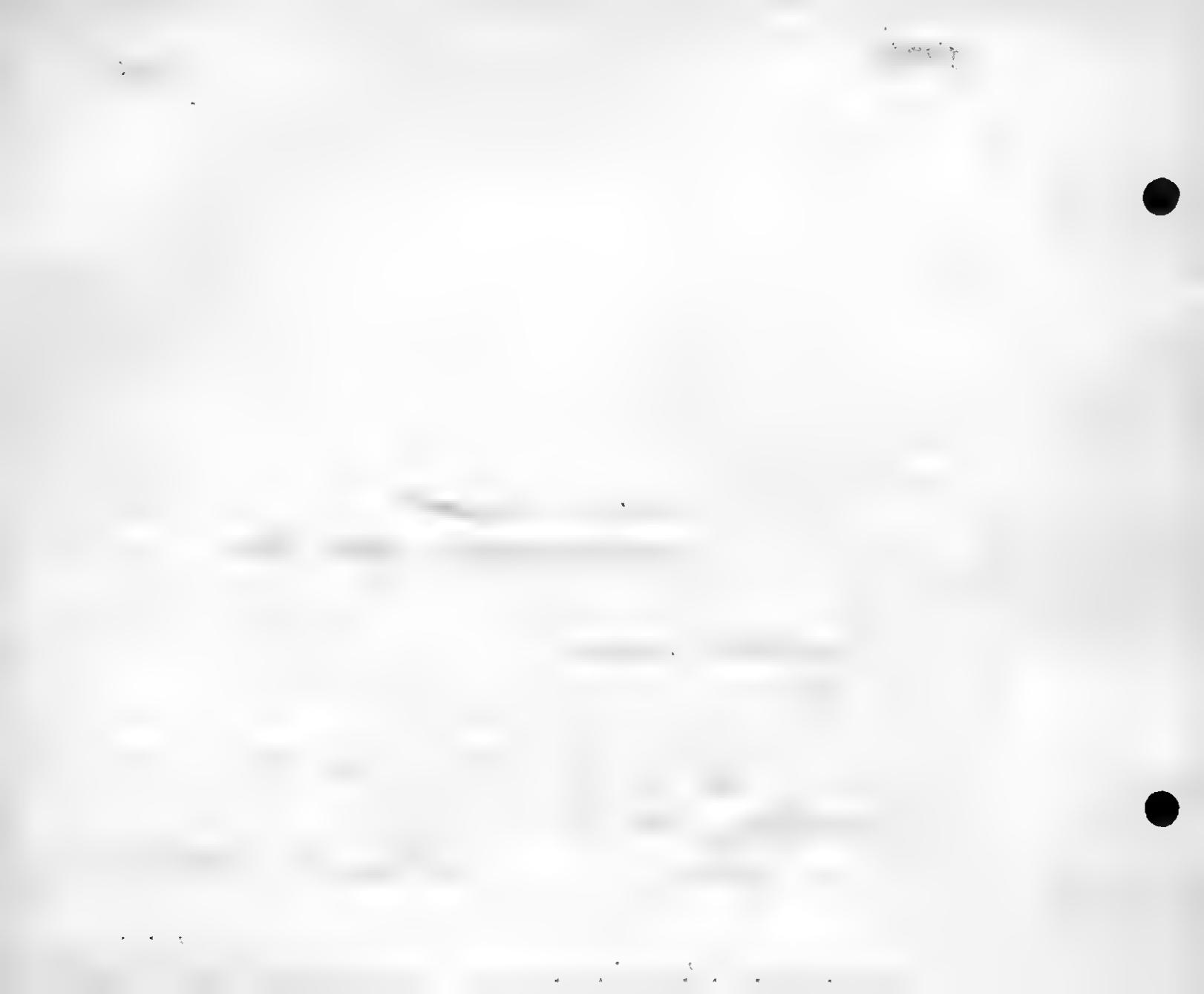
## CERTIFICATE OF DEATH

17304

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body. Any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>		c. LENGTH OF STAY IN b <i>9 1/2 yrs</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>		d. STREET ADDRESS <i>5804 ROOSEVELT ST.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>LILLIAN FAHEY</i>		First: <i>LILLIAN</i>	Middle: <i>FAHEY</i>
		Last: <i>BLACK</i>	4. DATE OF DEATH <i>DEC 3 1966</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>MARCH 3-1884</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9. AGE (In years last birthday) <i>82 yrs.</i>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>NEW ORLEANS, LA.</i>	
13. FATHER'S NAME <i>CHARLES PATRICK FAHEY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>577-01-8549</i>	
17. INFORMANT <i>LILLIAN FAHEY BLACK</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerotic heart disease</i> DUE TO (c)	
19. MEDICAL CERTIFICATION <i>? Perforated Viscus</i>		20. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Dec 19 1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10</i> , 19 <i>66</i> to <i>Dec 3</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Dec 2</i> , 19 <i>66</i> , and that death occurred at <i>125 M.</i> from causes and on the date stated above.		22a. SIGNATURE <i>Mr. Kelley On P</i>	
22b. DATE SIGNED <i>12/11/66</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>W.H. Kelley</i>		22d. ADDRESS <i>218 Wisconsin Ave Bethesda MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-7-1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Glenwood Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington D.C.</i>	
24. FUNERAL DIRECTOR <i>Joseph Lawler's Sons Inc.</i>		25a. ADDRESS <i>5130 Wisc. Ave. N.W. Wash. DC.</i>	
25b. REG'D BY REGISTRAR <i>Charles Judge</i>		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17314

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17305

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Montgomery</b>			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>Maryland</b>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c LENGTH OF STAY IN lb Rockville		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>			d STREET ADDRESS <b>4401 Independence Street</b>		
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <b>Gregory</b>			First <b>M.</b>	Middle <b>Boboltz</b>	Lost
S. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-27-66</b>	9 AGE (In years lost birthday) yrs <b>2 1/2</b>
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10b KIND OF BUSINESS OR INDUSTRY <b>none</b>	11 BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>David A. Boboltz</b>			14. MOTHER'S MAIDEN NAME <b>Florence Buehler</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO <b>none</b>	17. INFORMANT <b>David Boboltz</b>	Address <b>4401 Independence St., Rockville, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>924.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <b>Acute Asphyxiation in Crib, etiology undetermined.</b>					
INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury Part or Part that item 18) <b>Decedent was apparently in a asphyxiated with his crib by covers.</b>		
20c. TIME OF INJURY Month, Day, Year <b>50 Hour 12-18 1966</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory street, office bldg, etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Rockville Montgomery Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Belden R. Reap</i> M.D. EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D. Pathologist</i>					
22. DATE SIGNED <b>12/18/1966</b>					
23a. BURIAL, CREMATON, BURIAL AT SEA <input type="checkbox"/>	23b. DATE THEREOF <b>12/21/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>		
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>	ADDRESS <b>1331 Rockville</b>	25a. REC'D BY REGISTRAR <b>Pike</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
Date <b>DEC 22 1966</b>		Date <b>DEC 22 1966</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17315

**CERTIFICATE OF DEATH**

17306

**10. HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be signed within 24 hours after death.

**10. FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or by the hospital or attending physician, page 4 may be retained by the hospital or attending physician. If either the attending physician or the funeral director signs this certificate, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN b <i>years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring,</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>4602 Landgreen Street</i>		d. STREET ADDRESS <i>4602 Landgreen Street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mrs MARGARET</i>	First <i>BOCHICCHIO</i>	Middle <i></i>	Last <i>December</i>
4. DATE OF DEATH <i>August 10, 1894</i>	Month <i>15</i>	Day <i>19</i>	Year <i>66</i>
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>72 yrs</i>
9. AGE (In years last birthday) <i>72 yrs</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. IF UNDER 24 HRS Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (County & State or foreign country) <i>Dunmore, Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>Vito Sabato</i>	14. MOTHER'S MAIDEN NAME <i>Carmella Sabi</i>	17. INFORMANT <i>Lee Funeral Home, Linden, New Jersey</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>	16. SOCIAL SECURITY NO. <i>129-09-3067</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>400.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause knot. <i>Arteriosclerotic heart disease</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) (State) <i></i>	
21. I certify that (I) (this hospital) attended the deceased from <i>7 May</i> , 19 <i>66</i> to <i>15 Dec</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>19 May 19 66</i> and that death occurred at <i>6:30 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Richard Delaney</i>		22b. DATE SIGNED <i></i>	
22c. PHYSICIAN'S NAME (Type) <i>Richard Delaney</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>4323 Harvard Drive, S. S., Md.</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Dec. 19, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Calvary Cemetery</i>	23d. LOCATION (City or Town) <i>Long Island, New York</i>
24. FUNERAL DIRECTOR <i>John B. Thomas</i>	ADDRESS <i>8434 Georgia Ave.</i>	25a. REC'D BY REGISTRAR <i>DEC 19 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15 (4) 20 M 1/66			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17316

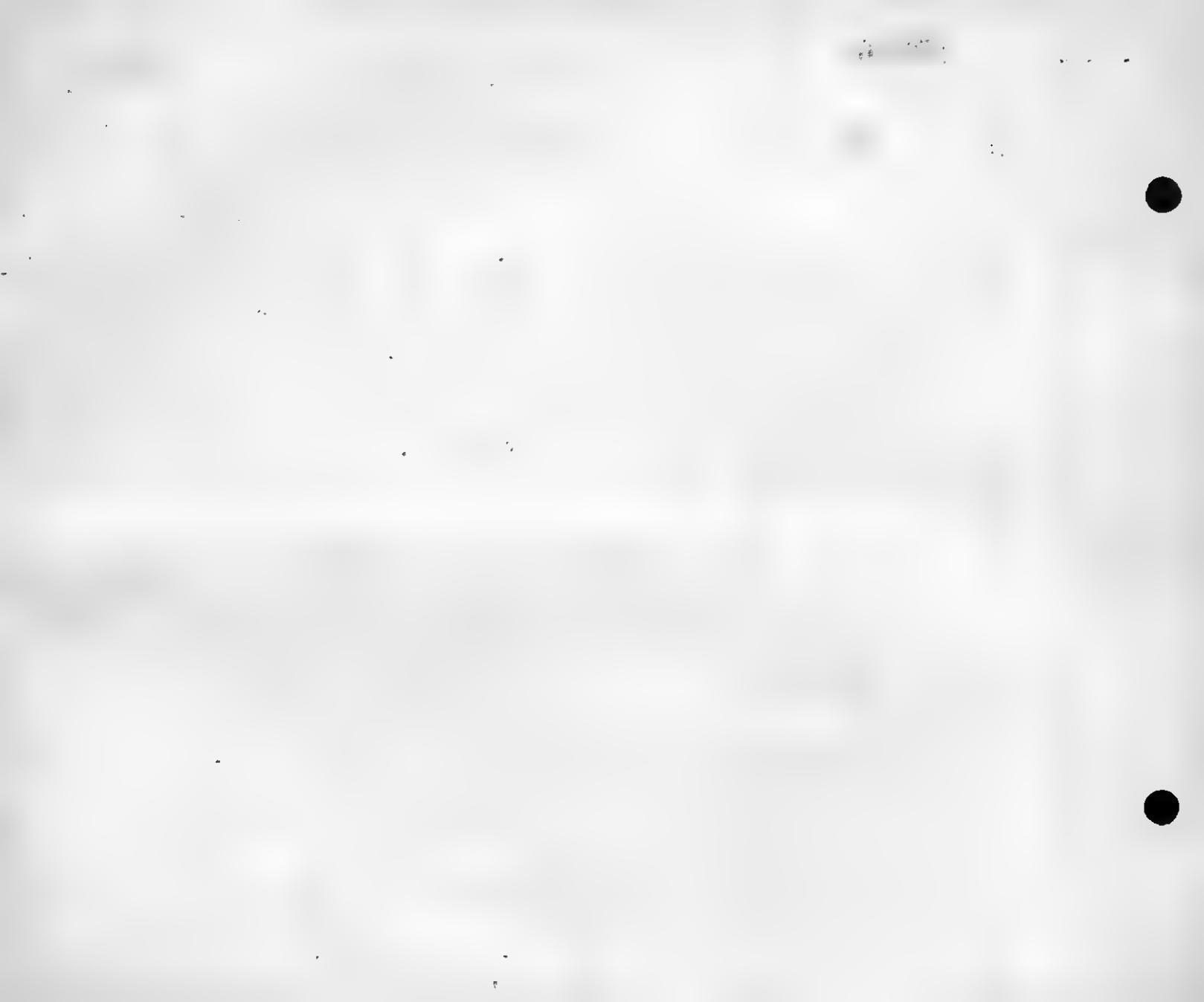
## CERTIFICATE OF DEATH

17387

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN b e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville Maryland</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>311 - Twinbrook Parkway</i>		d. STREET ADDRESS <i>311-Twinbrook Parkway.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Mary</i>		First <i>E.</i>	Middle <i>Boquel</i>		
4. DATE OF DEATH Month <i>12</i>		Day <i>20</i>	Year <i>1966</i>		
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>8-4-18</i>		
9. AGE (In years last birthday) <i>48 yrs</i>		10. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SECRETARY</i>		10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State or foreign country) <i>Pennsylvania</i>		12. FATHER'S NAME <i>Cornelius McCool</i>			
13. MOTHER'S MAIDEN NAME <i>Mary Flynn</i>		14. INFORMANT Address <i>Joseph P. Boquel-husband same item #2</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Joseph P. Boquel-husband same item #2</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Metastases with liver failure</i> DUE TO <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 mos.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Dept.</i>	(County) <i>1966</i>
21. I certify that (I) <i>this hospital</i> attended the deceased from <i>Sept.</i> , 1965, to <i>12/20</i> , 1966, that (I) <i>never</i> last saw the deceased alive on <i>12/14</i> 1966, and that death occurred at <i>8:30</i> M, from causes and on the date stated above		22b. DATE SIGNED <i>12/20/66</i>			
22a. SIGNATURE <i>G. Lennard Gold</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/20/66</i>
22c. PHYSICIAN'S NAME (Type) <i>G. Lennard Gold</i>		22d. ADDRESS <i>8641 Blawith Rd 25 Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/23/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cem.</i>	23d. LOCATION (City or Town) <i>Silver Spring, Maryland</i>	(County) (State)
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS <i>1331 Rock. Pike Rockville, Maryland</i>	25a. REC'D BY REGISTRAR <i>DEC 23 1966</i>	25b. REGISTRAR'S SIGNATURE <i>over Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17317

Item 8 Film 547 72167/66 mh

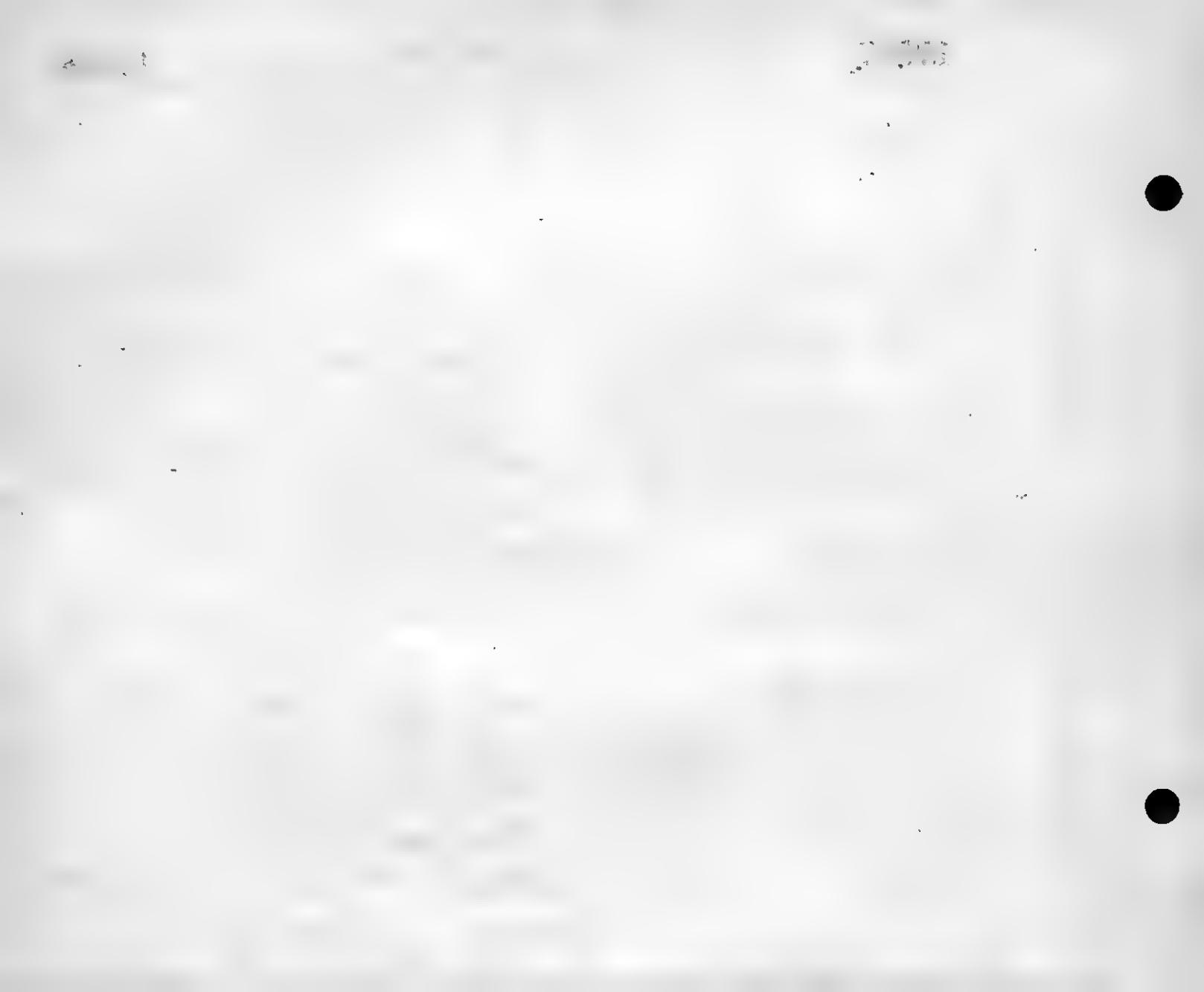
## CERTIFICATE OF DEATH

17308

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the certificate, page 3 should be detached for use as the burial-transit permit. Then ~~please~~ remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c. LENGTH OF STAY IN b <i>15 days</i>		
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>			d. STREET ADDRESS <i>2602 Jennings Rd.</i>		
3. NAME OF DECEASED First <i>VERCY</i> Middle <i>Grubbs</i> Last <i>Boyd</i>			4. DATE OF DEATH Month <i>12</i> Day <i>- 20 - 1966</i> Year		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>7/20/1900</i>		9. AGE (In years lost birthday) <i>66 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		
11. BIRTHPLACE (County & State, or foreign country) <i>Warren, Arkansas</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Oliver Grubbs</i>			14. MOTHER'S MAIDEN NAME <i>LuluBelle StJohn</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>		16. SOCIAL SECURITY NO <i>217-46-7626</i>		17. INFORMANT Name <i>William L. Boyd</i> Address <i>2602 Jennings Road Silver Spring, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>Generalized Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>14 days</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Generalized Arteriosclerosis</i> <i>Year</i> (c) <i>Arteriosclerotic Heart Disease</i> <i>5 year</i>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Cambridge</i> (County) <i>Norfolk</i> (State) <i>Va.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>10/19/59</i> to <i>12/20/66</i> , that (I) (we) last saw the deceased alive on <i>12/20/66</i> , and that death occurred at <i>12:30 p.m.</i> M. from causes and on the date stated above.					
22a. SIGNATURE <i>John J. Curry</i>			22b. DATE SIGNED <i>12/20/66</i>		
22c. PHYSICIAN'S NAME (Type) <i>John J. Curry M.D.</i>		22d. ADDRESS <i>10620 Georgia Ave. Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 23, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Riverside Cemetery</i>	
24. FUNERAL DIRECTOR <i>John S. Jones</i>		24a. ADDRESS <i>844 Georgia Ave. Silver Spring, Md.</i>		23d. LOCATION (City or Town) (County) (State) <i>Campostella, Norfolk, Va.</i>	
24b. FUNERAL DIRECTOR <i>John S. Jones</i>		24c. ADDRESS <i>John E. Purphy, Inc.</i>		25a. REC'D BY REGISTRAR <i>DEC 23 1966</i>	
24d. FUNERAL DIRECTOR <i>John E. Purphy, Inc.</i>		24e. ADDRESS <i>844 Georgia Ave. Silver Spring, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>John E. Purphy</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17318

CERTIFICATE OF DEATH

17309

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>16</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda, Md.</i>	
f. STREET ADDRESS <i>5807 Ryland Drive</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edgar J. Bristow</i>		Last <i>BRISTOW</i>	4. DATE OF DEATH Month <i>12</i> Day <i>25</i> Year <i>1966</i>
S SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-26-16</i>
9. AGE (In years last birthday) <i>50 yrs</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Deb.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Bristow</i>		14. MOTHER'S MAIDEN NAME <i>Elsie Hollis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service <i>WW I Yes.</i>		16. SOCIAL SECURITY NO. <i>221-01-2013</i>	
17. INFORMANT <i>Wife Hanna Bristow</i>		18. Address <i>Same as Item 2.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Liver Failure</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Cirrhosis of the liver</i> <i>Unknown</i> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic bronchitis &amp; Emphysema</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or Town) <i></i> (County) <i></i> (State) <i></i>			
21. I certify that (1) <i>(This hospital)</i> attended the deceased from <i>1965</i> , 19 <i>66</i> , to <i>12-25</i> , 19 <i>66</i> , that (1) <i>(we)</i> last saw the deceased alive on <i>12-25</i> 19 <i>66</i> , and that death occurred at <i>6:25 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Morris Perry</i>		22b. DATE SIGNED <i>12-28-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Morris Perry, M.D.</i>		22d. ADDRESS <i>11602 Georgia Avenue Silver Spring</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-29-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Natl Cem.</i>
23d. LOCATION (City or Town) <i>Arlington, Virginia</i>		(County) <i></i> (State) <i></i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS <i></i>	25a. REC'D. BY REGISTRAR DATE <i>DEC 30 1966</i>
		25b. REGISTRAR'S SIGNATURE <i></i>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2<sup>nd</sup> should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VI

17319

**CERTIFICATE OF DEATH**

17310

1 PLACE OF DEATH a. COUNTY , Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>			d. STREET ADDRESS <i>7911 13th St., N. W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print)	First <i>Otilia</i>	Middle <i>(NMD)</i>	Last <i>Brockaway</i>	4. DATE OF DEATH <i>Dec. 23</i>	Month <i>1966</i>				
S SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 23, 1872</i>	9 AGE (In years last birthday) <i>94 yrs.</i>	IF UNDER 1 YEAR Months <i>48</i>	IF UNDER 24 HRS. Days <i>44</i>	Hours <i>Reservoir Rd.</i>	Min. <i>Revere</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Cuba</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Jose Martinez Amores</i>			14. MOTHER'S MAIDEN NAME <i>Miria Diaz</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) <i>No None</i>		16. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>Mrs. Charles H. Sewall N. W., Wash. D. C.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <i>49IX</i> IMMEDIATE CAUSE (a) <i>Bronchopneumonia, Beltein</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>{</i>		DUE TO (b) DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>atherosclerotic cardiovascular Disease</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>(County)</i>		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 17, 1966</i> , to <i>Dec 23, 1966</i> , that (I) (we) last saw the deceased alive on <i>Dec. 23, 1966</i> , and that death occurred at <i>— M.</i> from causes and on the date stated above						22b. DATE SIGNED <i>Dec 23, 66</i>			
22a. SIGNATURE <i>Gene U. Cohen, M.D.</i>			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <i>Gene U. Cohen, M. D.</i>			22d. ADDRESS <i>1106 Spring St., Silver Spring, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 27, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Rock Creek Cemetery C. Glen Carter 8434 Georgia Ave. Silver Spring, Md.</i>		23d. LOCATION (City or Town) <i>Washington, D. C.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>C. Glen Carter Warner E. Pumphrey, Inc.</i>			RECD BY REGISTRAR <i>DEC 30 1966</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATEMENT  
HEALTH DEPT.

If my delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 to be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17320

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17311

1 PLACE OF DEATH a COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE				
Montgomery Maryland		Maryland b COUNTY Montgomery				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Germantown.		c LENGTH OF STAY IN lb 14 yr.				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D.		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Germantown.				
f STREET ADDRESS R.F.D.		g IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3 NAME OF DECEASED (Type or print)		First	Middle			
John Ezra		Buffington	Lost			
S SEX	6 COLOR OR RACE	7 MARRIED	8 DATE OF BIRTH			
M.	W.	<input type="checkbox"/> NEVER MARR ED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED X	Oct 3 1918			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)			
Farm Laborer TENANT			Maryland			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Raymond B. Buffington		Margaret Eyer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no; if unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT			
None		216-18-8117	Shirley Furry Union Bridge Daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Address INTERVAL BETWEEN ONSET AND DEATH 30 years.				
Coronary Insufficiency Acute- Cardio Vascular Disease-						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b)	years.			
(c)		DUE TO				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John G. Ball		MD	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		JOHN G. BALL		MD	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State)
BURIAL 12-20-66		PIPE CREEK		Open CARROLL County MD		
FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Old Hufnagel & Sons UNION BRIDGE MD				DATE DEC 21 1966		Charles Judge



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17321

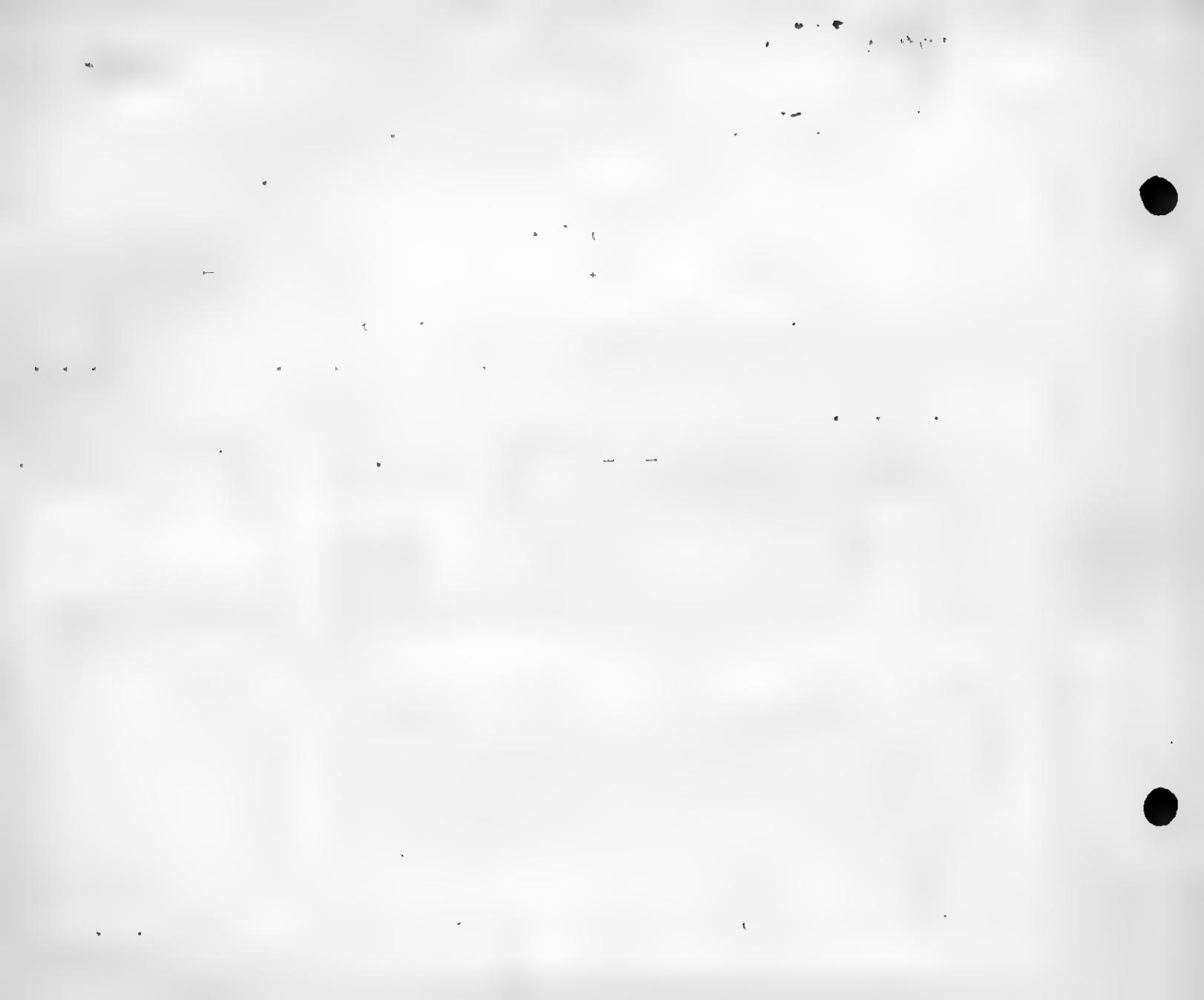
## CERTIFICATE OF DEATH

17312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MD.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4970 BATTERY LANE BETHESDA, MD.</b>		d. STREET ADDRESS <b>4970 BATTERY LANE</b>	
3. NAME OF DECEASED (Type or print) <b>MARTHA</b>		First <b>T.</b>	Middle <b>BURCH</b>
Last <b>12-1</b>		4 DATE OF DEATH <b>12-1</b>	Month Year <b>1966</b>
S SEX <b>female</b>	6 COLOR OR RACE <b>cau.</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. OATE OF BIRTH <b>SEPT. 19, 1870 96 yrs</b>		9. AGE (in years last birthday) <b>96 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>LOVINGSTON, VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DR. WM. T. TURNER</b>		14. MOTHER'S MAIDEN NAME <b>ELLA ESTES</b>	
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>577-20-0774</b>	
17. INFORMANT <b>MARTHA B. WALKER</b>		Address <b>4970 BATTERY LA.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Amenia</b> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c) <b>Sensility (96 yrs old)</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) <b>Cancerous l-Burst-not operated upon</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , to <b>Nov 30, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 30, 1966</b> , and that death occurred at <b>1215</b> M, from causes and on the date stated above.		22b. DATE SIGNED <b>12-1-66</b>	
22a. SIGNATURE <b>Arch. L. Riddick MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/>	MEDECATOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>DR. ARCHL. RIDDICK</b>		22d. ADDRESS <b>1835 Eye St N.W. Wash DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Dec 5, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Glenwood Cemetery</b>		23d. LOCATION (City or Town) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH Gowler's Sons Inc. WASH DC</b>		ADDRESS <b>WASH DC</b>	25a. REC'D BY REGISTRAR <b>DEC 3 1966</b>
		OATE	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



Item 12x21 Film 385 2-1-MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE  
HEALTH DEPT.

17322

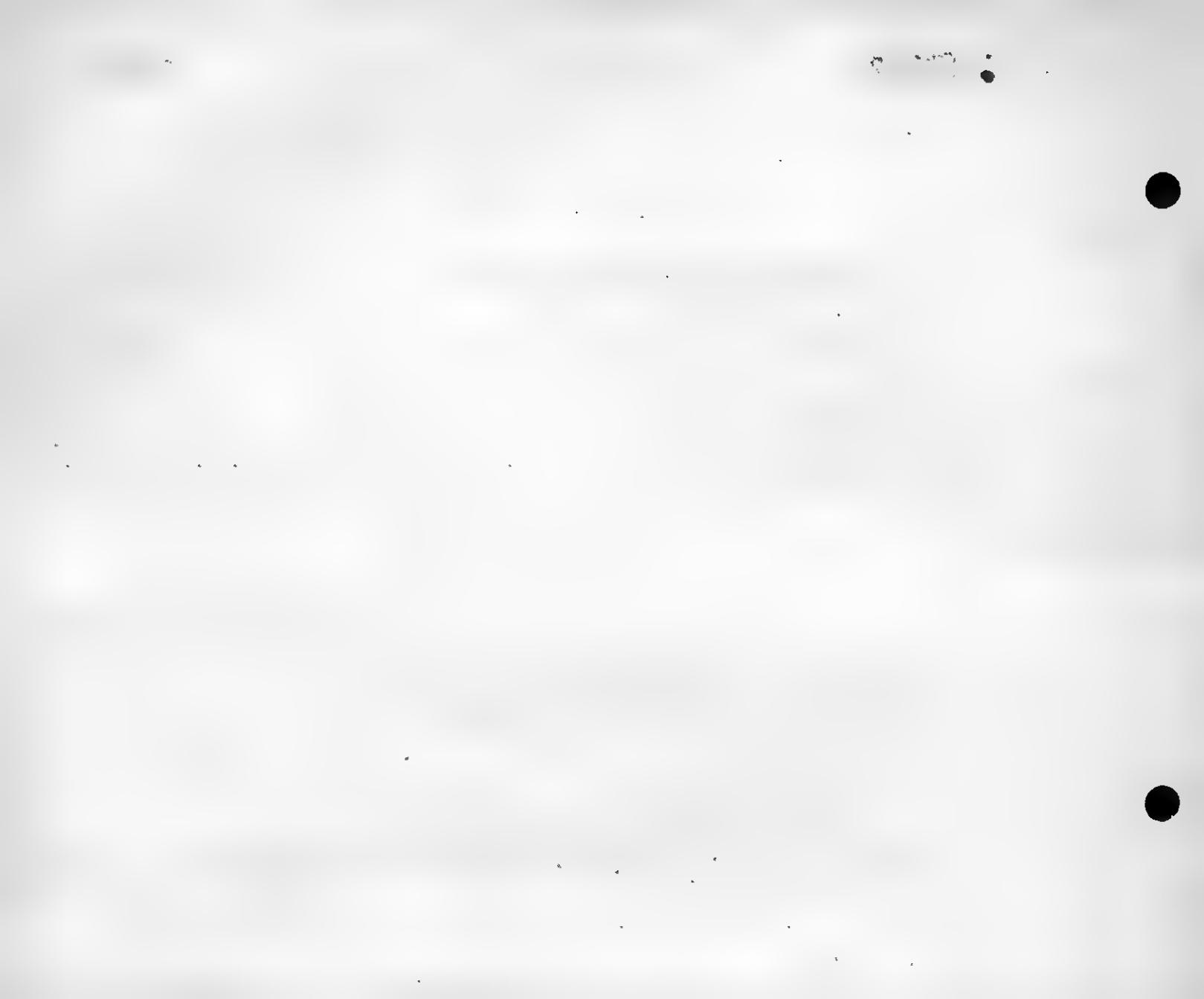
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17313

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If it is necessary, please execute the certificate, writing the word "pending" in pencil, in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN lb <i>2 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1911 East West Hwy.</i>		d. STREET ADDRESS <i>1911 Eastwest Hwy</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <i>Francis</i>	Middle <i>Henry</i>	Last <i>Burger</i>
4 DATE OF DEATH	Month <i>12</i>	Day <i>6</i>	Year <i>1966</i>
5 SEX <i>Male</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH <i>10-9-07</i>	9 AGE (In years last birthday) <i>59</i>	F UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Taxi cab owner &amp; Operator</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Transportation</i>	11 BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	12 CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>Frederick Burger</i>	14. MOTHER'S MAIDEN NAME <i>Johanna Dilger</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service <i>No</i>	16. SOCIAL SECURITY NO <i>214-30-2418</i>	17. INFORMANT <i>P. Michael Cook, Atty. N. W., Wash., D. C.</i>	18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>501X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Leop</i>	CHIEF MEDICAL EXAMINER MD	ASSISTANT MEDICAL EXAMINER MD	22 DATE SIGNED <i>Dec. 6, 1966</i>
EXAMINER'S NAME (Type) <i>Belden R. Leop, M.D.</i>	DEPUTY MEDICAL EXAMINER Address (Street, city, town, & county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Dec. 9, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>
24. FUNERAL DIRECTOR <i>John B. Thomas</i>	ADDRESS <i>4715 11th St., N.W. 8434 Georgia Ave.</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 14 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
Warren E. Pumphrey, Inc.			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17323

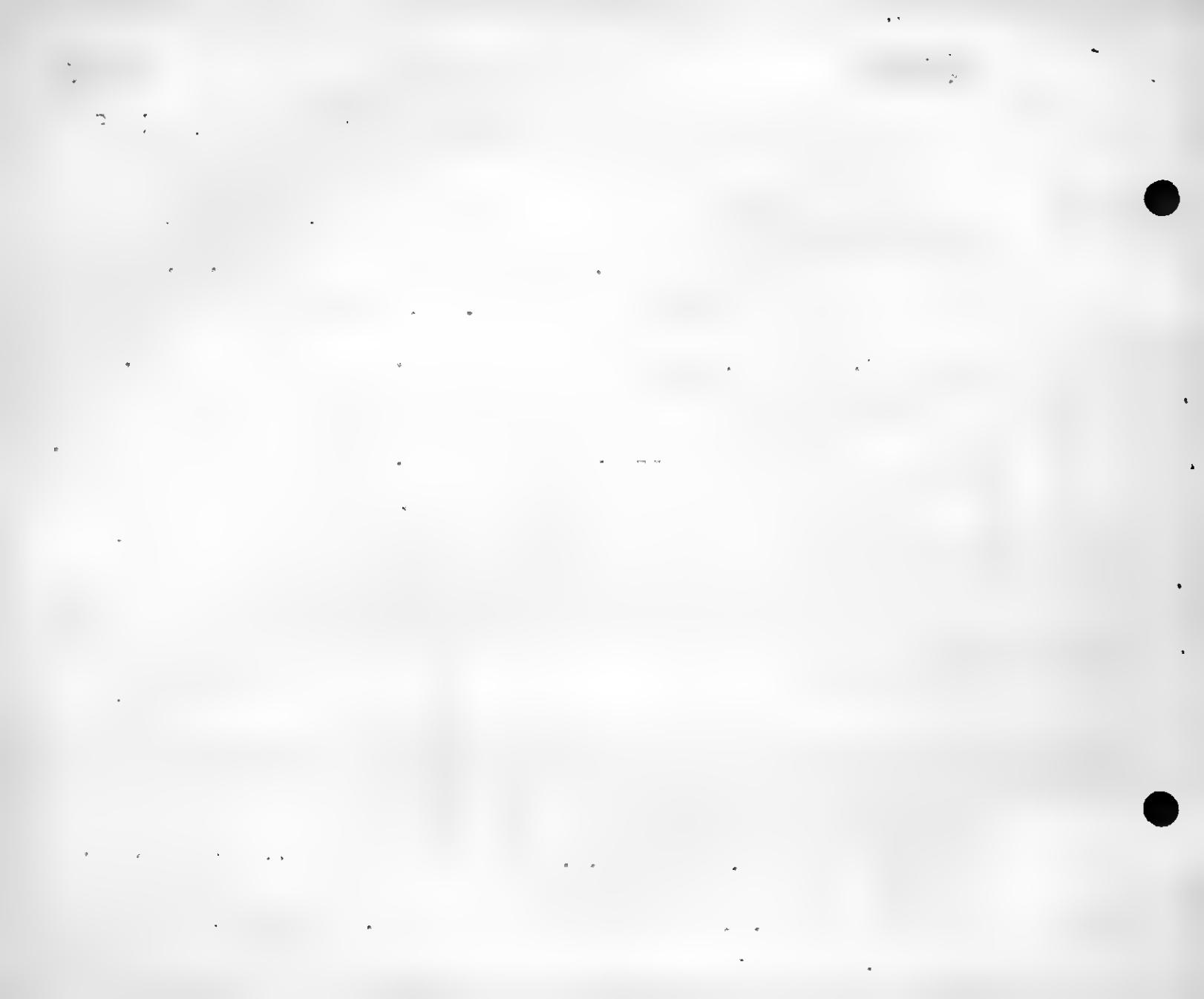
CERTIFICATE OF DEATH

17314

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pogs 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>			d. STREET ADDRESS <b>11901 Jubal Early Court</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>John</b>		First <b>O.</b> Middle <b>Butz</b>	4. DATE OF DEATH Month <b>Dec.</b> Day <b>5,</b> Year <b>1966</b>		
S SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 11, 1916</b>		9. AGE (in years lost birthday) <b>55 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bur. of Stand.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gov't</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>	
13. FATHER'S NAME <b>Grover Butz</b>			14. MOTHER'S MAIDEN NAME <b>Sara Owens</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>160-18-6438</b>		17. INFORMANT <b>Wife</b> Address <b>Mabel I. Butz</b> Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. <b>420.1</b> (b) <b>Coronary occlusion</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Arlington</b> (County) <b>Virginia</b> (State)
21. I certify that <b>11</b> (this hospital) attended the deceased from <b>10/14/1957</b> to <b>12/5/1966</b> , that <b>11</b> (we) last saw the deceased alive on <b>12-5-1966</b> , and that death occurred at <b>5A M</b> , from causes and on the date stated above.					
22o. SIGNATURE <b>Alfred S. Norton</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/5/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Alfred S. Norton, M.D.</b>		22d. ADDRESS <b>7710 Dwight Dr., Bethesda, Md.</b>			
23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 7, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Natl Cem.</b>		23d. LOCATION (City or Town) <b>Arlington</b> (County) <b>Virginia</b> (State)
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS		25o. REC'D BY REGISTRAR <b>DEC 9 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**M**

**17324.**

**CERTIFICATE OF DEATH**

**17315**

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician.

Page 4 may be retained by the hospital or attending physician.  
director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11 **Deceased by Medical examiner Dr. Bender for S. J. M. Sturte**

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <b>maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash San Hospital</b>		d. STREET ADDRESS <b>8716 Bradford Rd</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <b>Barbara</b>	Middle <b>Ann</b>	Last <b>Byrd</b>
4 DATE OF DEATH Month <b>12</b>	Month <b>12</b>	Day <b>23</b>	Year <b>1966</b>
5 SEX <b>Female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8 DATE OF BIRTH <b>11-16-31</b>	9. AGE (In years from last birthday) <b>35</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hswf</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>James Parker</b>	14. MOTHER'S MAIDEN NAME <b>Evelyn Stuart</b>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>578-40-8535</b>	17. INFORMANT <b>Mother (mrs. Evelyn Parker)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMOVARY CONGESTION</b>		INTERVAL BETWEEN ONSET AND DEATH	
conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>592 X</b>			
DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>		14R	
DUE TO (c) <b>Chronic GLOMERULONEPHRITIS</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>10820 Georgia Ave</b>
20f. (City or town) <b>Wheaton</b>		(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> to <b>1966</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>11:55 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>K. Bender</b>		22b. DATE SIGNED <b>12-23-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Benne G. Bender MD</b>		22d. ADDRESS <b>10820 Georgia Ave Wheaton</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/27/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven</b>
23d. LOCAT ON (City or Town) <b>Silver Spring, Md.</b>		(County) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Tyson "heeler Funeral Home-1331 Rockville</b>		ADDRESS <b>Rockville, Md.</b>	25a. REC'D BY REGISTRAR <b>FIRE 2 J 1966</b>
25b. REGISTRAR'S SIGNATURE <b>J. W. Heeler</b>		DATE	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17325

## CERTIFICATE OF DEATH

Reg. Dist. No.

17316

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN lb <b>16 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		d. STREET ADDRESS <b>4209 FRANKLIN ST.,</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4209 FRANKLIN ST.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>NELLIE</b>	Middle <b>ESTHER</b>	Last <b>CAIN</b>	4. DATE OF DEATH <b>DEC. 10 1966</b>	Month <b>DEC.</b>	Day <b>10</b>	Year <b>66</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 21, 1877</b>	9. AGE (In years last birthday) <b>89</b>	IF UNDER 1 YEAR Months <b>0</b>	Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>GEORGE WILLIAM LOWE</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH ANN WOOD</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>ELIZABETH C. SWIFT 4209 Franklin St.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3.32 X DUE TO <i>Cerebral Thrombosis, progressive with hemiplegia</i> left 7 days Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arteriosclerosis, generalised</i> (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Emphysema, advanced, chronic</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>1951</b> , to <b>Dec 10, 1966</b> , that I last saw the deceased alive on <b>December 10, 1966</b> , and that death occurred at <b>4107 M.</b> from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>M.D. 4740 Chevy Chase Dr.</b> DATE SIGNED <b>12/10/66</b>								
ACTUAL SIGNATURE <b>Stewart Clapp</b>								
PHYSICIAN'S NAME (Type) <b>Stewart Clapp M.D. Chevy Chase 15 Md.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>12-14-66</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>BETHESDA, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>DEC 15 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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✓  
✓



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17326

CERTIFICATE OF DEATH

17317

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>6 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Eleanor</i>	Middle <i>M.</i>	Last <i>Callahan</i>
4. DATE OF DEATH Month <i>December</i>	Day <i>15</i>	Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <i>Jan. 13, 1916</i>	9. AGE (in years last birthday) <i>50 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>	10b. KIND OF BUSINESS OR INDUSTRY Gov't.	11. BIRTHPLACE (County & State, or foreign country) <i>Louisiana</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Felix Horst VonMeehow</i>	14. MOTHER'S MAIDEN NAME <i>Maude Miesse</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Catherine A. Callahan - daughter</i>	18. 1505 Date <del>add</del> Court Alex. Va.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>100% Bronchial Carcinoma</i>		10 mos.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>(None)</i>
20f. (City or town) <i>(None)</i>		(County) <i>(None)</i> (State) <i>(None)</i>	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Sept. 1966</i> to <i>12/15, 1966</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>12/14, 1966</i> , and that death occurred at <i>6:04 AM</i> , from causes and on the date stated above.			
22o. SIGNATURE <i>G. Lennard Gold</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/15/66</i>
22c. PHYSICIAN'S NAME (Type) <i>G. Lennard Gold, M.D.</i>		22d. ADDRESS <i>8641 Colesville Rd., Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/19/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's</i>
23d. LOCATION (City or Town) <i>Annapolis, Maryland</i>		(County) <i>(None)</i> (State) <i>(None)</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		ADDRESS <i>131 Rock. Pike Rockville, Md.</i>	25a. REC'D BY REGISTRAR <i>DEC 19 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17327

## CERTIFICATE OF DEATH

17318

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Puerto Rico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 16 <b>67 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. STREET ADDRESS <b>210 Chiquita Street</b>	
3. NAME OF DECEASED (Type or print) <b>Delores</b>		First <b>Carmona</b>	Middle <b>CANLAS</b>
4. DATE OF DEATH <b>December 21 1966</b>		5. GENDER <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>
7. MARRIED WIDOWED <b>Married</b>		8. DATE OF BIRTH <b>Mar. 30, 1932</b>	
9. AGE (In years last birthday) <b>34 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	
11. IF UNDER 24 HRS Days <b>0</b>		12. IF UNDER 24 HRS Hours <b>0</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Paula Santana</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>unknown</b>	
17. INFORMANT <b>#106 Fajardo</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any which gave rise to immediate cause (a), slating the underlying cause <b>Glomerulonephritis</b> (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Naval Hospital, Bethesda, Md.</b>
20f. (City or town) <b>Dec. 21, 1966</b>		(County) (State)	
21. I certify that <b>(P)</b> (this hospital) attended the deceased from <b>Oct. 13, 1966</b> to <b>Dec. 21, 1966</b> , that <b>(P)</b> (we) last saw the deceased alive on <b>Dec. 21, 1966</b> , and that death occurred at <b>1215 M</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>Dec. 21, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Kinney, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>24 Dec. 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Natillo</b>
24. FUNERAL DIRECTOR <b>Rinaldi Funeral Home 7400 Georgia Ave., N. W. Washington, D. C.</b>		25a. ADDRESS <b>7400 Georgia Ave., N. W. Washington, D. C.</b>	25b. REC'D BY REGISTRAR <b>DEC 27 1966</b>
		25c. REGISTRAR'S SIGNATURE <b>John J. Rinaldi</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17328

CERTIFICATE OF DEATH

17319

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1029 Grandin Ave.</b>		e. STREET ADDRESS <b>1029 Grandin Ave.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Margaret</b>		First <b>Margaret</b>	Middle <b>Elizabeth</b>	Last <b>CASE</b>	4. DATE OF DEATH <b>12 - 23 1966</b>	Month <b>12</b>	Day <b>23</b>	Year <b>1966</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b>	8. DATE OF BIRTH <b>Nov. 26, 1875</b>	9. AGE (In years last birthday) <b>91 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Philip Sherrer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Catherine Schrider</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>31 220-54-0817</b>		17. INFORMANT <b>Mrs. Pauline Case</b>		Address <b>Same as Item 2.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Infarction</b> INTERVAL BETWEEN ONSET AND DEATH <b>75 hrs</b>								
33xx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> <b>78 hrs</b>								
DUE TO (b) <b>Cerebral Thrombosis</b> <b>78 hrs</b>								
DUE TO (c) <b>Cerebral Arteriosclerosis</b> <b>78 hrs</b>								
DUE TO (c) <b>Cerebral Arteriosclerosis</b> <b>78 hrs</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
<b>Chronic cystitis &amp; prolapus</b>								
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <b>4/21, 1966</b> to <b>12/23, 1966</b> , that (I) (we) last saw the deceased alive on <b>12/23, 1966</b> , and that death occurred at <b>12/23/66</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>Stephen N. Jones</b>		22b. DATE SIGNED <b>12/23/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>STEPHEN N. JONES</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <b>✓ MED. DIRECTOR</b> <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>1809 Viers Mill Rd. Rockville, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-28-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 30 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>		



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

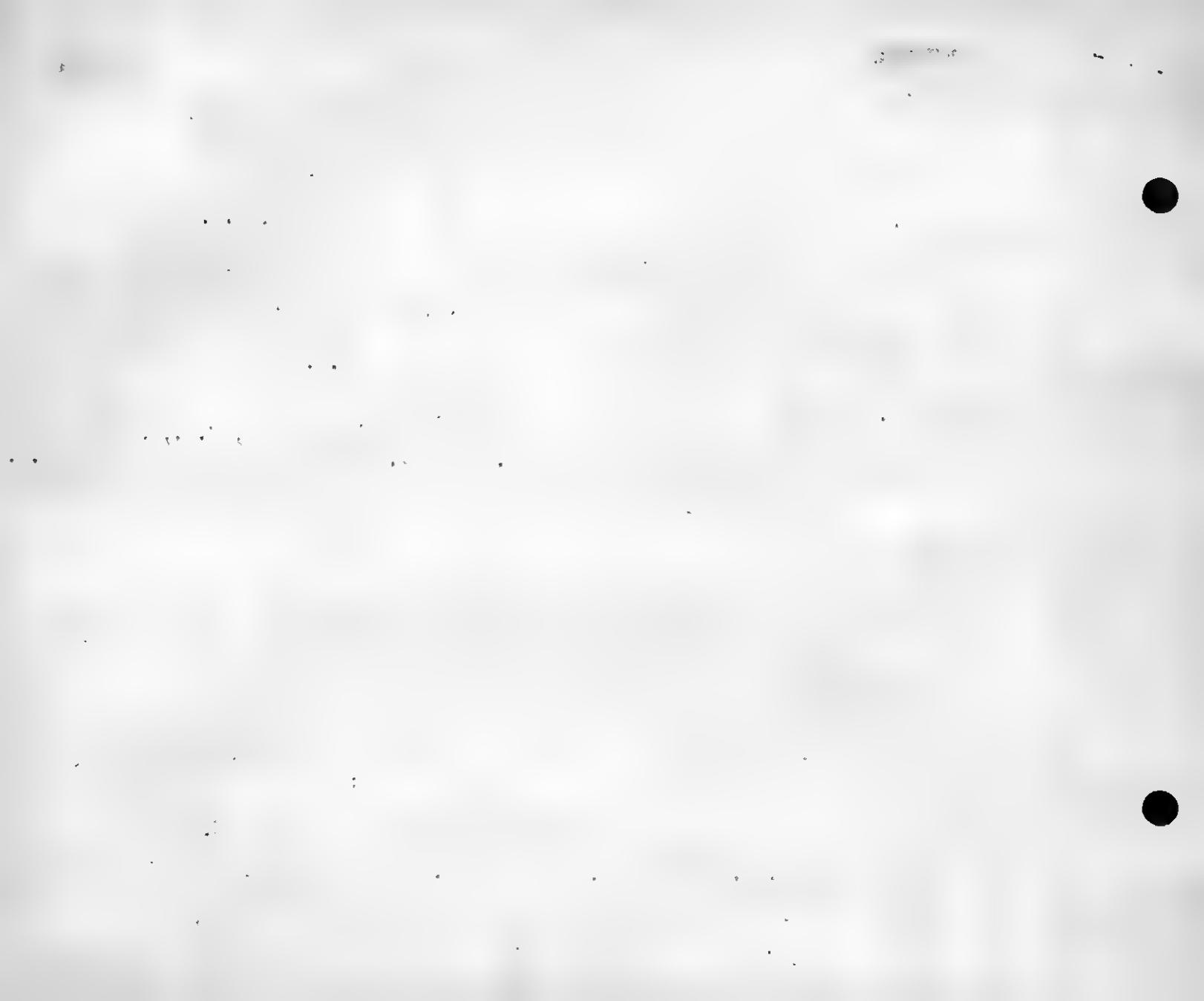
17329

CERTIFICATE OF DEATH

17320

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>		e. STREET ADDRESS <b>800 4th Street, S.W.</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Harry Winfield CAULSEN II</b>	First <b>Harry</b>	Middle <b>Winfield</b>	Last <b>CAULSEN</b>
4 DATE OF DEATH <b>December 2 1966</b>	Month <b>December</b>	Day <b>2</b>	Year <b>1966</b>
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Cauc</b>	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>26 APRIL 1942</b>	9. AGE (In years last birthday) <b>24 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USCG</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>Harry W. CAULSEN</b>		14. MOTHER'S MAIDEN NAME <b>Sarah WIMBERLY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO <b>SEP 65 -2 DEC 66</b>	17. INFORMANT <b>800 4th Street, S.W., Washington, D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>Malignant Lymphoma</b>		INTERVAL BETWEEN ONSET AND DEATH	
210.2 IMMEDIATE CAUSE (a) <b>Malignant Lymphoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Washington, D.C.</b>		(County) <b>D.C.</b>	(State) <b>D.C.</b>
21. I certify that (X) this hospital attended the deceased from <b>23 November 1966</b> , to <b>2 December 1966</b> (to <b>1</b> ) (we) last saw the deceased alive on <b>2 December 1966</b> , and that death occurred at <b>9:15 A.M.</b> from causes and on the date stated above			
22a. SIGNATURE <i>R. J. Kinney</i>		22b. DATE SIGNED <b>12-3-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LCDR R. J. KINNEY, MC, USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-6-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery, Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 6 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15 (4) 20 M 1/66			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

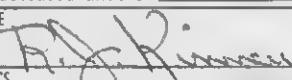
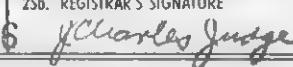
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**17330**

**CERTIFICATE OF DEATH**

**17321**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <b>U? S? Naval Hospital</b>			d. STREET ADDRESS <b>9121 McDonald Drive</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Frank</b>	Middle <b>Tenney</b>	Last <b>CHAMBERLIN</b>	4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>1966</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 AUG 91</b>	9. AGE (In years last birthday) <b>75</b> yrs.
10a. U.S. AL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>Franklin T. CHAMBERLIN</b>			14. MOTHER'S MAIDEN NAME <b>Nannie Lee NAYLOR</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>1917 - 1950</b>		16. SOCIAL SECURITY NO <b>220-44-5843</b>		17. INFORMANT <b>5100 Dorset Ave., Chevy Chase, Md.</b> Mr. Donal Lee CHAMBERLIN (Brother)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia Bilateral</b> INTERVAL BETWEEN ONSET AND DEATH <b>49UX</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Pneumococcus</b>					
DUE TO (b) <b>Pneumococcus</b>					
DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Carcinoma of Pancreas with metastases to adjacent lymph nodes and liver; Emphysema; Arteriosclerotic heart disease</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <b>I</b> (this hospital) attended the deceased from <b>1 DECEMBER 1966</b> , to <b>1 DECEMBER 1966</b> , that <b>I</b> (we) last saw the deceased alive on <b>1 DECEMBER 1966</b> , and that death occurred at <b>7:45 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE 					
22c. PHYSICIAN'S NAME (Type) <b>LCDR R. J. KINNEY, MC, USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-5-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery, Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> <del>Adressal</del> Home, 7557 Wisconsin Avenue, Bethesda, Maryland					
25a. REC'D BY REGISTRAR <b>DEC 6 1966</b>				25b. REGISTRAR'S SIGNATURE 	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8, 9, 12, 13, 14, 15, G384 1/12/67 mh

17331

## CERTIFICATE OF DEATH

17322

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Mont. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>30 mins.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If, not in hospital, give street address) <b>Suburbane</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
3. NAME OF DECEASED (First Middle Last) <b>John August Christiansen</b>		d. STREET ADDRESS <b>7811-Stratford St.</b>	
3. NAME OF DECEASED (First Middle Last) <b>John August Christiansen</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (First Middle Last) <b>John August Christiansen</b>		f. DATE OF DEATH <b>Dec. 17 1966</b>	
3. NAME OF DECEASED (First Middle Last) <b>John August Christiansen</b>		g. Month Day Year <b>Dec. 17 1966</b>	
3. NAME OF DECEASED (First Middle Last) <b>John August Christiansen</b>		h. IF UNDER 1 YEAR Months Days Hours Min.	
3. NAME OF DECEASED (First Middle Last) <b>John August Christiansen</b>		i. IF UNDER 24 HRS. Minutes	
4. SEX <b>Male</b> COLOR OR RACE <b>white</b>		7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
4. SEX <b>Male</b> COLOR OR RACE <b>white</b>		8. DATE OF BIRTH <b>1880</b>	
4. SEX <b>Male</b> COLOR OR RACE <b>white</b>		9. AGE (In years 1st birthday) <b>86 yrs</b>	
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner-Ornamental Iron- Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner-Ornamental Iron- Retired</b>		11. BIRTHPLACE (Country & State, or foreign country) <b>Norway</b>	
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner-Ornamental Iron- Retired</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carl Christiansen</b>		14. MOTHER'S MAIDEN NAME <b>Johanna Erickson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <b>No yes WW I</b>		16. SOCIAL SECURITY NO <b>569-44-2669</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <b>No yes WW I</b>		17. INFORMANT Daughter Address <b>Mrs. E. I. Jones Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4/20.1</b>		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4/20.1</b>		DUE TO <b>(a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4/20.1</b>		DUE TO <b>(b) <u>Ventricular fibrillation</u></b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4/20.1</b>		DUE TO <b>(c) <u>Coronary thrombosis</u></b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 26, 1966</b> to <b>Dec. 17, 1966</b> , that (I) (we) last saw the deceased alive at <b>Dec. 17, 1966</b> , and that death occurred at <b>3:50 P.M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>DEC. 17, 1966</b>	
22a. SIGNATURE <b>Robert G. Angle</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT G. ANGLE</b>		22d. ADDRESS <b>5009 Del Ray Ave. Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		23b. DATE THEREOF <b>12-18-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Ogden City Cem.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		23d. LOCATION (City or Town) (County) (State) <b>Ogden, Utah</b>	
24 FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS	
24 FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 23 1966</b>	
24 FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17332

## CERTIFICATE OF DEATH

17323

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH  
a. COUNTY

Montgomery Maryland

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LENGTH OF STAY IN 16

Bethesda 280.a.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospita, give street address)

Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

a. STATE Md.

b. COUNTY Mont.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Germantown 151

d. STREET ADDRESS

H. # 2-Box 110

e. IS RESIDENCE  
ON A FARM?YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First Harry

Middle

Last Clipper

S. SEX

m

6. COLOR OR RACE Negro

WIDOWED MARRIED  NEVER MARRIED DIVORCED 

7. DATE OF BIRTH

11-11-1888

8. AGE (In years  
last birthday)  
yrs

78

12-30

1966

Day

Year

9. IF UNDER 24 HRS  
Months Days Hours Min10. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Retired LABORER

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (County &amp; State, or foreign country)

Maryland

12. CITIZEN OF WHAT  
COUNTRY U.S.

13. FATHER'S NAME

Jack Clipper

14. MOTHER'S MARRIED NAME

Martha ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Daughter Jerlene Ellis - Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO

(b)

DUE TO

(c)

Myocardial infarction

Coronary arteriosclerosis

INTERVA. BETWEEN  
ONSET AND DEATH

420.1

Conditions, if any, which gave

rise to immediate cause (a),

stating the underlying cause

last.

19. WAS AUTOPSY  
PERFORMED?YES  NO 

20a. MEDICAL CERTIFICATION

20b. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH

(If either, notify MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

20d. INJURY OCCURRED

While  Not While at work  of work 

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

17-30 1966

to 12-30 1966, that (I) (we) last

saw the deceased alive on

12-27 1966, and that death occurred at

8:30 p.m.

from causes and on the date stated above.

22a. SIGNATURE

Dr. Bruce MD

M.D. ATTENDING

PHYS.  MED.DIRECTOR  STAFFPHYS. 

22b. DATE SIGNED

12-31-66

22c. PHYSICIAN'S  
NAME (Type)

D.L. Body

22d. ADDRESS

309 Viers Mill Rd. Mont. Md.

Rockville

12-31-66

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

14/67

23b. DATE THEREOF

Seneca Cemetery

23c. NAME OF CEMETERY OR CREMATORI

Seneca Cemetery

23d. LOCATION (City or Town)

Seneca

(County)

(State)

Montgomery

Md.

24. FUNERAL DIRECTOR

Robert L. Snowden Rockville, Md.

ADDRESS

DATE JAN 6 1967

25a. REC'D BY REGISTRAR

Charles Judge

25b. REGISTRAR'S SIGNATURE

Charles Judge

Date

12-31-66

26. VR A15 (4)

20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17333

CERTIFICATE OF DEATH

17324

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <i>Maryland</i>		Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c LENGTH OF STAY IN 1b <i>6 days</i>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		d. STREET ADDRESS <i>8318 14<sup>th</sup> Ave.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San. and Hospital</i>				e. DATE OF DEATH Month <i>December</i>		Year <i>1966</i>	
3. NAME OF DECEASED (Type or print) <i>Amelia Ellen Coble</i>		First	Middle	Last		Day	Year
S. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>1-16-90</i>	9. AGE (In years lost birthday) <i>76 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Paterson</i>		14. MOTHER'S MAIDEN NAME <i>Martha Johnson</i>		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital Records</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>3.31X</i>		DUE TO <i>Cerebral vascular accident</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral arteriosclerosis</i>		DUE TO (c)		8 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>bullet hole</i>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work Not While at work <input type="checkbox"/> <input checked="" type="checkbox"/>	
				20e. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>October</i> , 19 <i>58</i> to <i>Present</i> , 19 <i>66</i> , that (I) <i>last</i> saw the deceased alive on <i>12-21 1966</i> , and that death occurred at <i>910</i> M. from causes and on the date stated above.		22a. SIGNATURE <i>James T. Kimble</i>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>SERUCH T. KIMBLE</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>12/23/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Presbyterian Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Williamsburg, Penna.</i>	
24. FUNERAL DIRECTOR <i>The S. H. Hines Company - Washington, DC</i>		ADDRESS		25a. REC'D. BY REGISTRAR DATE <i>DEC 27 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Judge</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**M**

**17334**

**17325**

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

**Medical Examiner notified and Approved**

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>D.C.</i> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b <i>17 mo.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash. D.C.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kensington Gardens - 3000 McCormick</i>			d. STREET ADDRESS <i>6517 Barnaby St. NW</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Edna</i>	Middle <i>S</i>	Last <i>Colbert</i>	4. DATE OF DEATH Month <i>Dec</i>	Year <i>17 1966</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>NEVER MARRIED</i>	8. DATE OF BIRTH <i>May 15, 1896</i>	9. AGE (In years lost birthday) <i>70 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i> IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Michigan</i>	12. CITIZEN OF WHAT COUNTRY? <i>US</i>
13. FATHER'S NAME <i>Edward A. Freyler</i>			14. MOTHER'S MAIDEN NAME <i>Nellie Caelan</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>123-45-6789</i>		17. INFORMANT <i>Maurice R. Colbert, Same as #2</i>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CVA</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause</i>					
DUE TO (b) <i>Atherosclerosis + Hypertension</i>			10 yrs		
DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Involuntary Melancholia</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>None</i>	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>July 26, 1966</i> to <i>12/20/66</i> , 1966, that (I) (we) last saw the deceased alive on <i>Oct 20 1966</i> , and that death occurred at <i>1220 N. L St. NW</i> M, from causes and on the date stated above.					
22a. SIGNATURE <i>John B. Marbury</i>		M.D. <input type="checkbox"/> ATTENDING PHYS MED. DIRECTOR <input type="checkbox"/> STAFF PHYS	22b. DATE SIGNED <i>12/17/66</i>		
22c. PHYSICIAN'S NAME (Type) <i>John B. Marbury</i>		22d. ADDRESS <i>4545 - Conn Ave NW -</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/20/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Nat. Cem.</i>	23d. LOCATION (City or Town) <i>Arlington</i>	(County) <i>VA</i>	(State)
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Washington, D.C.</i>			ADDRESS <i>None</i>	25a. REC'D BY REGISTRAR <i>REC'D BY REGISTRAR</i>	25b. REGISTRAR'S SIGNATURE <i>REC'D BY REGISTRAR</i>
			DATE <i>DEC 21 1966</i>		



1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17333

17326

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY	Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Rockville, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
c. LENGTH OF STAY IN 1b	several weeks		11603 Magruder Lane 151				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Dr. James	G.	Conroy Sr.	Conroy	December 21	1966		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	12. IS RESIDENCE ON A FARM?
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3-8-1888	78 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Veterinarian			Maryland		U.S.A.		
13. FATHER'S NAME	Patrick Conroy		14. MOTHER'S MAIDEN NAME		Mary Davis *		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO.		17. INFORMANT		Address: 11630 Magruder Lane Rockville, Maryland		
WWar 1 and 2	220-443116		James G. Conroy Jr.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1. DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							
COPD pulmonary & lowered congestive heart failure known months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
Benzodiazepine Calmness							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 3 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
19							
21. I certify that (I) this hospital attended the deceased from 11/1/1966 to 12/21/1966, that (I) two last saw the deceased alive on 12/21/1966, and that death occurred at 108 M, from the causes and on the date stated above.							
22a. SIGNATURE MARCEL FORET 13/21/66							
22c. PHYSICIAN'S NAME (Type) MARCEL FORET 916 19th St NW Wash DC 20010							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Dec. 24-1966		23c. NAME OF CEMETERY OR CREMATORIUM St. John's Cath. Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701	
Burial							
24. FUNERAL DIRECTOR Elwood T. M.R.Etchison & Son		ADDRESS Whitmore Frederick, Md. 21701		25a. REC'D BY REGISTRAR UCU 1966		25b. REGISTRAR'S SIGNATURE James Judge	
				DATE			
VR A15 (4) 20M 1/65							



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17336

CERTIFICATE OF DEATH

17327

**10 HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit slip. Then please remove carbon papers. **10c** and **2** should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Olney 24 minutes		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Boy		Last Cook		4. DATE OF DEATH 12-12-66	Month 12- Doy 12- Year 1966
5. SEX Male Male		6. COLOR OR RACE Negro WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-12-66		9. AGE (in years last birthday) Yrs		10. IF UNDER 1 YEAR Months Days Hours Min 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Roland C. Cook		14. MOTHER'S MAIDEN NAME Alice White		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Montgomery Gen. Hospital Address Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angina</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Failure of heart Expansion (distended veins)</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH min.			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) just saw the deceased alive on _____, 19_____, and that death occurred at 3:20 P.M. from causes and on the date stated above.					
22a. SIGNATURE <u>Chester Lee Ray Wagstaff</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec 12, 1966	
22c. PHYSICIAN'S NAME (Type) Dr. C. Wagstaff		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/13/66		23c. NAME OF CEMETERY OR CREMATORIAL Ash Memorial	
24. FUNERAL DIRECTOR Robert L. Snowden		ADDRESS Rockville, Md.		23d. LOCATION (City or Town) Sandy Spring (County) Md. (State)	
25a. REC'D. BY REGISTRAR DATE DEC 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 director, page 3 should be detached for use as the burial/transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17337 CERTIFICATE OF DEATH 17338											
Items 11, 19 & 21 m 6304 17337-166											
1. PLACE OF DEATH a. COUNTY		MARYLAND									
Montgomery		MARYLAND									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b									
Silver Spring		1 week									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Holy Cross Hospital									
e. STREET ADDRESS		9409 Garwood St.									
f. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
g. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
William John Cooper					Dec. 14			1966			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	12. COUNTRY	Months	Days	Hours
Male		Cauc.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7-30-14	52 yrs.			Md.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY		
Transportation Spec. U.S. Post			Md. Takoma Park, Md.			Md. Takoma Park, Md.			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
George H. Cooper			Estelle Brady								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes Give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		
No None			577-12-6064			Rita W. Cooper			INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral</u>			hemorrhage - l. frontal lobe								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b) <u>H. C.V.D.</u>								
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
19											
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 14, 1966</u> to <u>Dec. 17, 1966</u> ; that (I) (we) last saw the deceased alive on <u>Dec. 14, 1966</u> ; and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>D. Allen R. Keaf</u>											
22c. PHYSICIAN'S NAME (Type)			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			M.D. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>		
BENEDEN R. KEAF, M.D.									12/14/1966		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City, town or county) (State)		
Burial			Dec. 17, 1966			Washington National Cemetery			Suitland, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Glen Carter			(Greenlawn) 6434 Georgia Ave.			DEC 20 1966			Charles Judge		
Warren E. Pumphrey, Inc.			Silver Spring, Md.			DATE					



4 + 7  
17338

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17329

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of your death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if inst. list on Res. before admission) b. STATE <i>California</i>	
c. LENGTH OF STAY IN 1b <i>6 days</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Palo Alto</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. STREET ADDRESS <i>316 Fulton St</i>	
3 NAME OF DECEASED (Type or print) <i>John Oates</i>		First <i>J</i>	Middle <i>Oates</i>
4 DATE OF DEATH <i>12</i>	Month <i>11</i>	Doy <i>19</i>	Year <i>66</i>
5 SEX <i>M</i>	6 COLOR OR RACE <i>Caucasian</i>	7. MARRIED WIDOWED <i>A</i>	8. NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
9 AGE (In years last birthday) <i>52</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Stanford University, Peruv Indian</i>	11. BIRTHPLACE (State or foreign country) <i>Peru</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Donald</i>	14. MOTHER'S MAIDEN NAME <i>Madge Oates</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>212-36-2125</i>	17. INFORMANT <i>Joseph D. Appack, Laumont Ave., Sole</i>	Address <i>634 W. Elmwood</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchopneumonia -</i>	19. INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>		
20. CONDITIONS, IF ANY, WHICH GAVE Rise to immediate cause (a), stating the underlying cause <i>Chronic Alcoholism -</i>	21. DUE TO (b) <i>Chronic Alcoholism -</i> DUE TO (c)		
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fatty metamorphosis with cirrhosis</i>			
23. MEDICAL CERTIFICATION PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		24. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 25. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	
26. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		27. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	
28. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <i>Bethesda, Md.</i>	
30. ACTUAL SIGNATURE <i>John G. Ball</i>		31. DATE SIGNED <i>12/12/66</i>	
32. EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		33. LOCATION (City or Town) (County) (State) <i>SUITLAND, MARYLAND</i>	
34. BURIAL CREMATION, REMOVAL & TRANSPORT <i>CREMATION</i>		35. DATE THEREOF <i>12-13-66</i>	
36. NAME OF CEMETERY OR CREMATORIUM <i>CEDAR HILL CREMATORY</i>		37. REGISTRATION BY REG STRAP DATE <i>DEC 19 1966</i>	
38. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>		39. REG STRAP'S SIGNATURE <i>Charles Judge</i>	
40. ADDRESS <i>BETHESDA, MARYLAND</i>			
41. VR A15ME (5) 6M 1/67			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

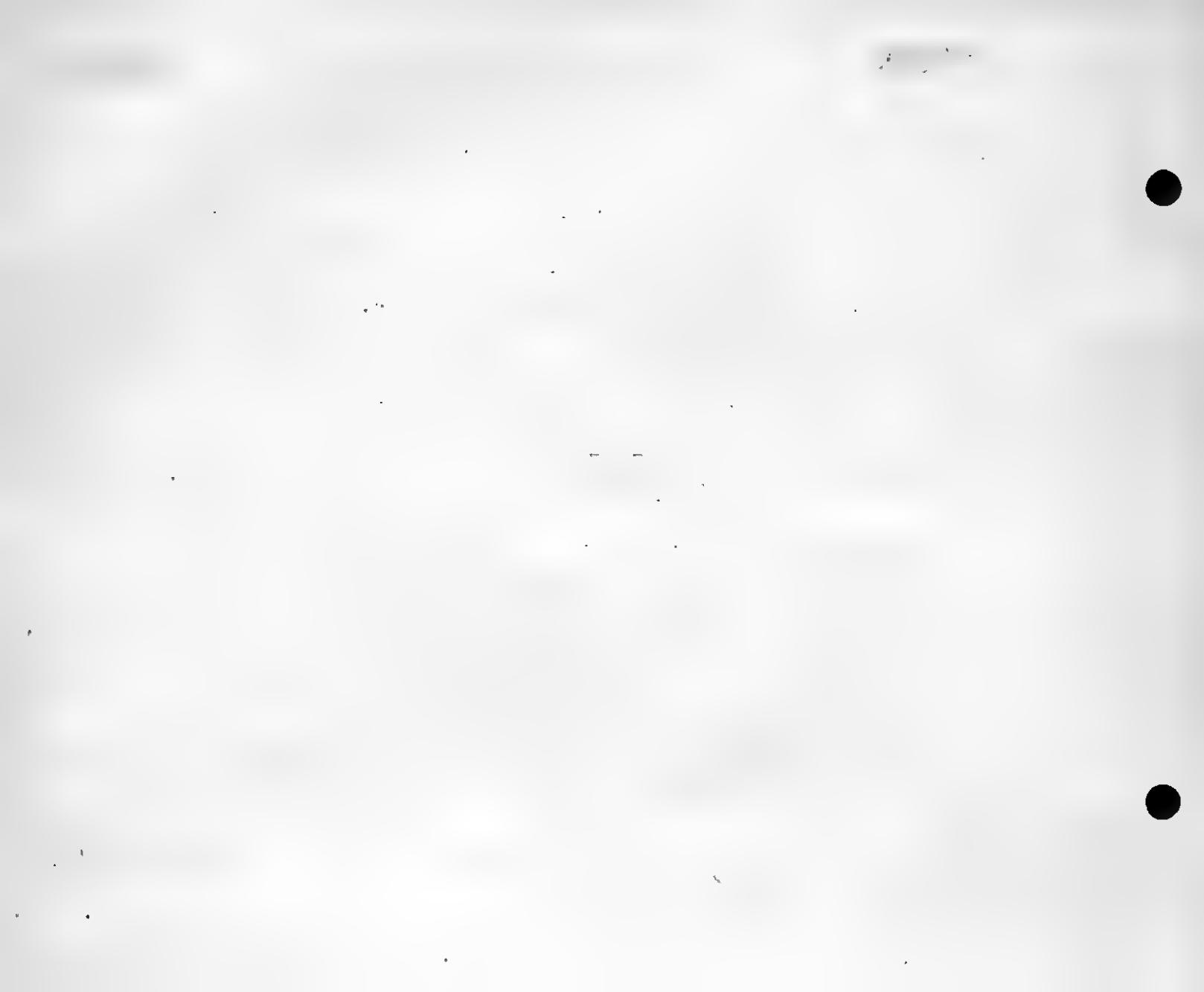
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17339

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17338

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. San. + Hospital</i>		e. STREET ADDRESS <i>Dartmouth st. manor</i>	
3 NAME OF DECEASED (Type or print) <i>Estelle (mn) Councill</i>		4 DATE OF DEATH Month <i>12</i>	Day Year <i>20 1966</i>
S SEX <i>Female</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 NEVER MARRIED DIVORCED <input type="checkbox"/>
9 DATE OF BIRTH <i>10-9-96</i>		10 AGE (In years past birthday) yrs <i>70</i>	11 IF UNDER 1 YEAR Months Days Hours Min
10a US AL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Homemaker</i>		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>
12 CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13 FATHER'S NAME <i>John Gibson</i>	
14 MOTHER'S MAIDEN NAME <i>Annie Norman</i>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16 SOCIAL SECURITY NO <i>577-01-0168</i>		17 INFORMANT <i>Mr. Hersey H. Councill (Hus)</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Coronary Artery Disease</i>		19 INTERVAL BETWEEN ONSET AND DEATH <i>Acute Coronary Insufficiency</i>	
DUE TO (b) DUE TO (c)		Coronary Artery Heart Dilat.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <i>None</i>
20f (City or town) <i>None</i>		(County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Cap M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Belden R. Cap M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town or County) <i>None</i>		22. DATE SIGNED <i>12/20/1966</i>	
23a BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>12/23/66</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Cemetery</i>
23d LOCATION (City or Town) <i>Prince Georges Co. Md.</i>		(County) (State)	
24 FUNERAL DIRECTOR <i>The S. H. Hines Company</i>		ADDRESS <i>Washington, D.C.</i>	25a REC'D BY REGISTRAR DATE <i>REC 27 1966</i>
			25b REGISTRAR'S SIGNATURE <i>J. H. Hines</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17340

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17331

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Med cert's Office along with form PM3. Page 5 may be rejoined for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
c. LENGTH OF STAY IN b. <i>2 weeks</i>		d. STREET ADDRESS <i>8204 Woodhaven Blvd</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Jeremiah Joseph Courtney</i>		4 DATE OF DEATH <i>Dec. 2, 1966</i>	Month Day Year
S SEX <i>Male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED WIDOWED <i>-</i>	8 DATE OF BIRTH <i>2/16/14332</i>
9 AGE (in years last birthday) <i>72 yrs</i>	10 KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	11 BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>	12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13 FATHER'S NAME <i>JEREMIAH J. COURTNEY SR.</i>		14 MOTHER'S MAIDEN NAME <i>VALBORG HOLM</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16 SOCIAL SECURITY NO <i>NONE</i>	
17 INFORMANT <i>JEREMIAH Courtney SR.</i>		Address <i>ITEM 2</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>978X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Injuries, multiple, severe</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Fall from Cabin John Bridge</i>		DUE TO (b) <i>Sudden</i>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>jumped off bridge falling 102 feet</i>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c TIME OF INJURY Month, Day, Year <i>1:45 pm 12/2 1966</i>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>jumped off bridge falling 102 feet</i>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Bridge</i>		20f (City or town) (County) (State) <i>Cabin John, Mont. Md.</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John G. BALL</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <i>12/3/66</i>	
Address (Street, city, town, or county) <i>for Hawley Lorraine 5130 Wisconsin Ave N.W. D.C.</i>		23d LOCATION (City or Town) (County) (State) <i>GATE OF HEAVEN Cem. SILVER SPRING Mont. Md.</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12/5/66</i>	23c NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>GATE OF HEAVEN Cem. SILVER SPRING Mont. Md.</i>
24. FUNERAL DIRECTOR <i>for Hawley Lorraine 5130 Wisconsin Ave N.W. D.C.</i>		25a RECEIVED BY REGISTRAR <i>DEC 8 1966</i>	
		25b REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17341

CERTIFICATE OF DEATH

17332

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN lb <b>3½ years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8611 Brandt Place</b>		d. STREET ADDRESS <b>8611 Brandt Place</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>SAMUEL</b>		First <b>F.</b>	Middle <b>COX</b>
4. DATE OF DEATH <b>Dec. 7, 1966</b>		Month	Day Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Feb. 9, 1892</b>		9. AGE (in years lost birthday) <b>74 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer - U.S. Gov't</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>Abraham S. Cox</b>		14. MOTHER'S MAIDEN NAME <b>Annie Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>579-58-5806</b>	
17. INFORMANT <b>Wife Sophia E. Cox</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchicular carcinoma lung with metastases to Pleura and Brain.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>162.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>	
(b) <b>Metastases to Pleura and Brain.</b> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) <b>Decatur</b> (County) <b>St. Louis</b> (State) <b>Mo.</b>			
21. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>May 3, 1966</b> , to <b>December 7, 1966</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>12/7/66</b> , and that death occurred at <b>600P. M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>12/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. BLAINE FITZGERALD</b>		22d. ADDRESS <b>8218 Wisconsin Ave.</b> <b>Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-12-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Natl Cem.</b>
23d. LOCATION (City or Town) <b>Arlington</b> (County) <b>Virginia</b> (State)			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS	25a. REC'D BY REGISTRAR DATE <b>DEC 15 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17342

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17338

1. PLACE OF DEATH

a. COUNTY

Maryland

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1D

2. USUAL RESIDENCE (Where deceased died, if institution; Residence before admission)

a. STATE

b. COUNTY

Maryland Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

Potomac, Md. 3418 Calvert St.

e. IS RESIDENCE  
ON A FARM?  
YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year  
1966

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED

8. DATE OF BIRTH

9. AGE (In years  
last birthday)  
46 yrs.

10. IF UNDER 1 YEAR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

U. S. Navy

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Seattle, Wash.

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Glenn Creed

14. MOTHER'S MAIDEN NAME

Julia Welch

Address

15. WAS DECEASED EVER IN U.S. ARMY FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

Yes WW II

16. SOCIAL SECURITY NO.

17. INFORMANT

Wife

Klara N. Creed

Same as Item 2.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1. Due to

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) Due to

(c) Due to

Excessive (overdose) pneumonia  
2. Pericarditis chronic organizing  
3. Anemia due to bone marrow metastases

INTERVAL BETWEEN  
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

States following pneumonia for 2 weeks

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m.

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)  
(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

12-16-66

23c. NAME OF CEMETERY OR CREMATORIUM

Arlington Natl Cem.

23d. LOCATION (City, town or county) (State)

Arlington, Virginia

24. FUNERAL DIRECTOR

ADDRESS

ROBERT A. PUMPHREY, Bethesda, Maryland

25a. REC'D BY REGISTRAR

DEC 12 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



FOR STATE  
HEALTH DEPT.

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17343

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17334

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
<i>Montgomery</i> <i>Maryland</i>		<i>Md.</i> <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Bethesda D.O.A.</i>		<i>Rockville Wheaton</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>Suburban</i>		<i>4002 Randolph Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>E.</i>
		Last <i>Crickmer</i>	4. DATE OF DEATH Month <i>12</i> - Day <i>30</i> Year <i>1966</i>
S SEX <i>m</i>	6 COLOR OR RACE <i>gr</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH <i>7-9-1899</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Grocery Retired</i>		9. AGE (In years at time of death) <i>67 yrs</i>	
10c. FATHER'S NAME <i>Clayton. George Crickmer</i>		11. BIRTHPLACE (State or foreign country) <i>West Virginia.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. MOTHER'S MAIDEN NAME <i>Seebie Atkinson.</i>			
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>234-44-9200</i>	
17. INFORMANT <i>Son in Law</i>		Address <i>A H Conley - 4002 Randolph Rd.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exsanguination, instant</i>		INTERVAL BETWEEN ONSET AND DEATH	
162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) <i>Erosion, pulmonary artery</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		20f. (City or town) (County) (State)	
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-transit 12-30-66</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23b. DATE THEREOF <i>Linkous Cem.</i>		Address (Street, city, town, or county) <i>Tawzell, Virginia</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. RECEIVED BY REGISTRAR <i>JAN 5 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c &amp; d Film 1/16/67 pg

17344

## CERTIFICATE OF DEATH

17335

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>			b. COUNTY <b>Montgomery</b>		
c LENGTH OF STAY IN lb			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac / Silver Spring</b>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Manor Rest Home</b>			d STREET ADDRESS <b>17344/ Bldg 11 9604 Merwood Lane</b>		
			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) <b>LILLIAN</b>			First <b>E.</b>	Middle <b>CROSS</b>	4 DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>1966</b>
S. SEX <b>Female</b>	6. CO. OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>7/9/1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Eubank</b>			14. MOTHER'S MAIDEN NAME <b>Josie Chandler</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>578-52-5854A</b>		17. INFORMANT Address <b>James G. Cross-9604 Merwood Lane Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardiac arrest</b>			INTERVAL BETWEEN ONSET AND DEATH		
DUE TO <b>7330</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>senile heart disease</b>			DUE TO <b>years</b>		
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Senile dementia - arteriosclerosis</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Aug 67</b>	(County) <b>Dec</b> (State)
21. I certify that (I) (the hospital) attended the deceased from <b>Aug 67</b> , to <b>Dec</b> , 1966 that (I) (we) last saw the deceased alive on <b>Dec 12 1966</b> , and that death occurred at <b>8 P.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Marvin Wadler</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/30/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Marvin Wadler</b>		22d. ADDRESS <b>8105 Cindy Lane, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/31/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rockville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		ADDRESS <b>1531 Rock. Pike Rockville, Md.</b>	25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Marvin J. Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17345

## CERTIFICATE OF DEATH

17336

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 38 days		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			d. STREET ADDRESS 621 Hollywood Avenue		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)		First James	Middle Bernard	Last Crown	4. DATE OF DEATH Month December Day 15 Year 1966
5 SEX Male		6 COLOR OR RACE White	7 MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 18 March 1955
8. OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Elem. Nonos School		9. AGE (In years last birthday) 11 yrs	F. UNDER 1 YEAR Months Dofs Hours Min
11. BIRTHPLACE (Country & State, or foreign country) Bethesda Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard L. Crown, Jr.			14. MOTHER'S MAIDEN NAME Mary Ellen Thibadeau		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) If yes give war or dates of service) No None			16. SOCIAL SECURITY NO. None		
17. INFORMANT Bernard Crown			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO 1467 Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause lost		
			viremic 3 Days		
			(b) Overwhelming Infectious process, probably/laryngeal obstruction DUE TO		
			2 Days		
			(c) Tracheo-laryngitis secondary to (B) with/		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Juvenile Rheumatoid Arthritis			INTERVAL BETWEEN ONSET AND DEATH 5 Mths.		
20b. ACCIDENT WAS UNDER, YING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or Town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 7, 1966, to Dec. 15, 1966 that (I) (we) last saw the deceased alive on Dec. 15, 1966, and that death occurred at 11:15A.M. from causes and on the date stated above.					
22a. SIGNATURE David N. Sogho		PM M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 12/16/66			
22c. PHYSICIAN'S NAME (Type) David N. Sogho, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 20, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Rockville Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Walter E. Humphrey, Inc.		ADDRESS 8434 Georgia Avenue, Silver Spring, Maryland		25a. REC'D. BY REGISTRAR 1966	
				25b. REGISTRAR'S SIGNATURE moyage	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, removal, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17346

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17337

1 PLACE OF DEATH a COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE <b>West Virginia</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c LENGTH OF STAY N 1b d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Summersville W. Va 26651</b>	
d STREET ADDRESS <b>912 Main St.</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Maryie Maynie</b>		First <b>M</b> iddle <b>PEARL</b>	Last <b>Cutlip</b>
4 DATE OF DEATH <b>12-11-1966</b>		Month	Day Year
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH <b>9/13/86</b>	9 AGE (In years last birthday) <b>80 yrs</b>	F UNDER 1 YEAR Months	I IF UNDER 24 HRS Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11 BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12 CITIZEN OF WHAT COUNTRY? <b>US</b>	
13 FATHER'S NAME <b>JAMES NEIL</b>		14. MOTHER'S MAIDEN NAME <b>Lucy HESLIP</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>No</b>		16 SOCIAL SECURITY NO <b>?</b>	
17. INFORMANT <b>DAUGHTER MRS CAROLINE HOLDEN - TAHOMA PK. MD</b>		Address <b>790 FAIRVIEW AVE</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO } (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Cerebral infarct (at. parietal lobe) Cerebral arteriosclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg, etc.) 20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>R. Belden</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. HEAD M.D. u/w/</b>		22. DATE SIGNED <b>Dec. 10, 1966</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL + BURIAL DEC 14, 1966</b>		23b DATE THEREOF <b>23c NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>GROVES CEMETERY</b></b>	
24 FUNERAL DIRECTOR <b>R. Non. DeVol 2222 Wisconsin</b>		23d LOCATION (City or Town) (County) (State) <b>SUMMERSVILLE W. VIRGINIA</b>	
ADDRESS		25a REC'D BY REG STAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE DATE <b>DEC 10 1956</b>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17347

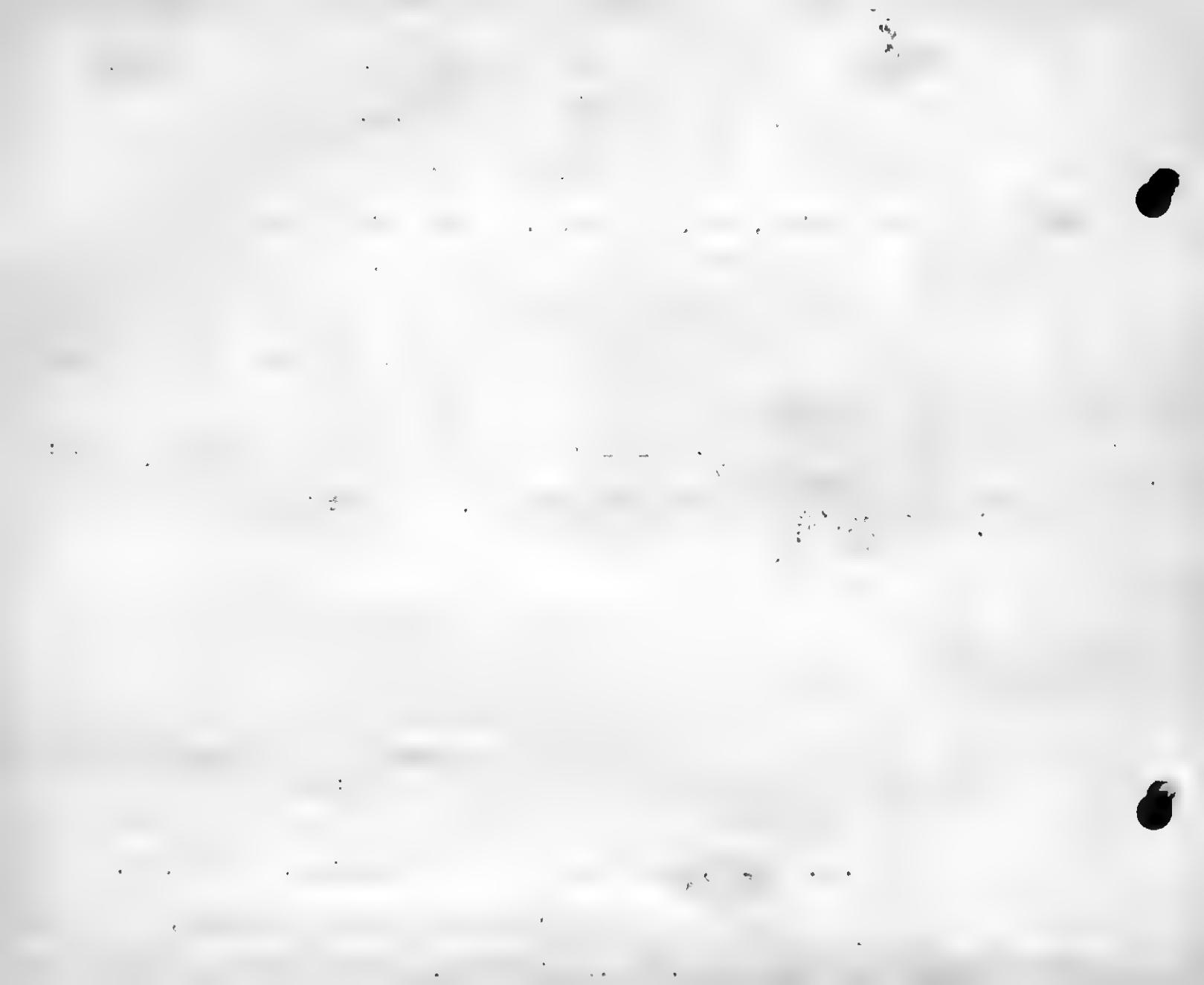
CERTIFICATE OF DEATH

17338

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived if institution Res dence before admission) a. STATE <b>Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN Tb <b>46 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, NNMC, Bethesda, Md.</b>		e. STREET ADDRESS <b>9920 Fairfax Square</b>	
3. NAME OF DECEASED (Type or print) <b>Leonard</b>		First <b>Leonard</b>	Middle <b>DENSMORE, JR.</b>
Last <b>DENSMORE</b>		4. DATE OF DEATH <b>December 31 1966</b>	Month Day Year
S SEX <b>Male</b>	6 COLOR OR RACE <b>Cau</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>11 March 1928</b>	9. AGE (In years last birthday) <b>38 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USMC</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Goshen, New York</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Leonard DENSMORE</b>		14. MOTHER'S MAIDEN NAME <b>Margaret DECKER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO <b>044-22-0373</b>	17. INFORMANT <b>Mrs. Carolyn Densmore</b>
		Address <b>9920 Fairfax Sq. Fairfax, Virginia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial Neoplasm, left frontal lobe</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO stating the underlying cause last. (c) DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm factory, street, office bldg., etc.) <b>Naval Hospital, Bethesda, Md.</b>
20f. (City or town) <b>Naval Hospital, Bethesda, Md.</b>		(County)	(State)
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>14 NOVEMBER 1966</b> to <b>31 DECEMBER 1966</b> that <b>(X)</b> (we) last saw the deceased alive on <b>31 DECEMBER 1966</b> , and that death occurred at <b>10:30 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>F. L. EDELMAN</b>		22b. DATE SIGNED <b>2 January 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. L. EDELMAN, LCDR MC USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 4, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Arlington National Cemetery</b>
24. FUNERAL DIRECTOR <b>Everly Funeral Home</b>		23d. LOCATION (City or Town) <b>Arlington, Virginia</b>	(County) (State)
		25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Clarke</b>



FOR STATE  
HEALTH DEPT.

1 M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201-

17348

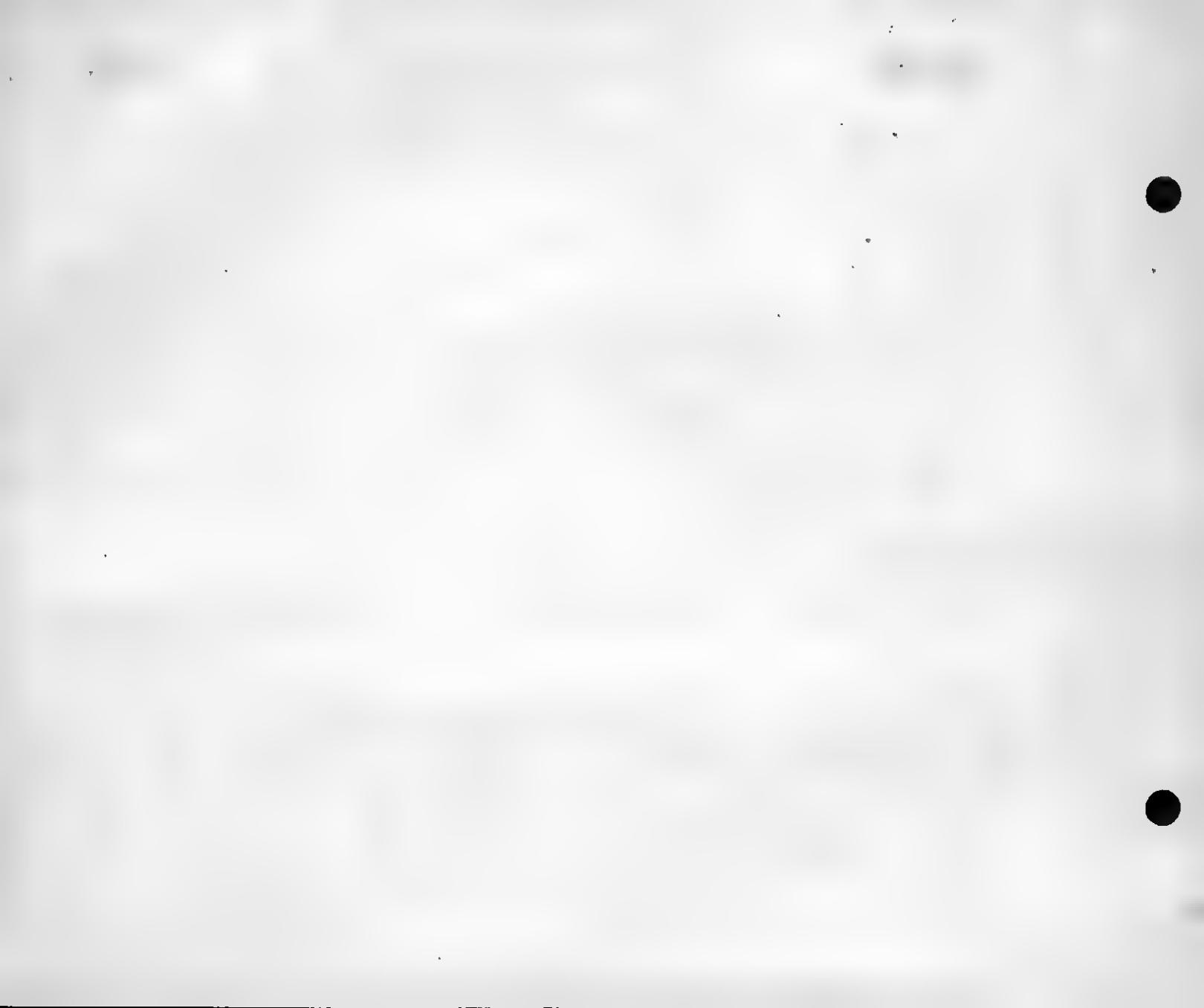
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17339

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PMB. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN TB. <i>T.O.A.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>none</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <i>Oscar Bryan Dillehay</i>	First Middle Dillehay Last	4 DATE OF DEATH <i>Dec. 7 1966</i>	Month Doy Year
5 SEX <i>male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>11/21/1886</i>
10a. OCCUPATION (Give kind of work done during most of working life even if retired) <i>House Painting</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John A. Dillehay</i>	14. MOTHER'S MAIDEN NAME <i>Bessie Keith</i>	Address <i>Comus, Md.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>	16. SOC. SECURITY NO <i>218-20-1805</i>	17. INFORMANT <i>John A. Dillehay</i>	18. INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Injuries multiple, sever-</i> sity		DUE TO (b) <i>to contact with auto</i>	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last		(c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Hit by passing Auto while walking on State Road #27-</i>		
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> AM <i>7:15 p.m. 12/7 1966</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street</i>	20f. (City or town) (County) (State) <i>Cedar Grove Mont. Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Bell</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED <i>12/8/66</i>	
EXAMINER'S NAME (Type) <i>Constance C. Hilton</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/10/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Hyattstown Methodist Hyattstown Montg. Md.</i>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <i>Constance C. Hilton Barnesville, Md.</i>	ADDRESS	25a. REC'D BY REG STRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
DATE <i>DEC 13 1966</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17349

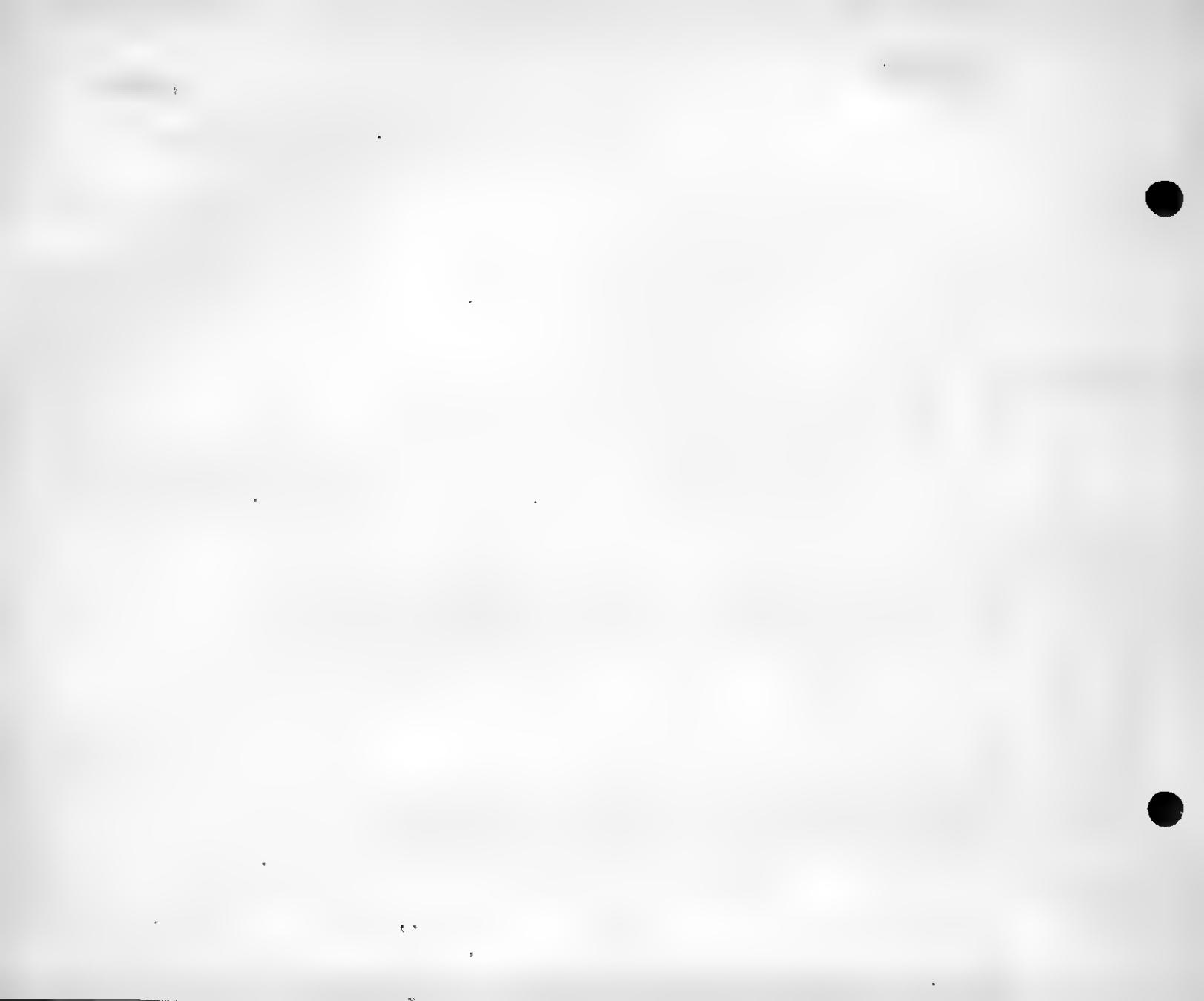
## CERTIFICATE OF DEATH

17349

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, write before admission)	
<i>Montgomery</i> Maryland		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 'b' <i>2 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>	
3. NAME OF DECEASED (Type or print)		First <i>Austin</i>	Middle Last 4. DATE OF DEATH <i>DIMMIE</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Oct. 8, 1903</i>		9. AGE (In years last birthday) <i>63</i>	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sanitary Comm.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>
13. FATHER'S NAME <i>Robert Dimmick</i>		14. MOTHER'S MAIDEN NAME <i>Unto</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Son - Kenneth - 2001 Savannah Rd. Wash. D.C.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rupture aortic aneurysm with cardiac tamponade</i>			
451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Medial necrosis, aorta</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>12/17, 1966</i>	
20g. (City or town) (County) (State)			
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>12/17, 1966</i> to <i>12/18, 1966</i> , that <input type="checkbox"/> (we) last saw the deceased alive on <i>12/18, 1966</i> and that death occurred at <i>3 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Marvin Wadler</i>		22b. DATE SIGNED <i>12/17/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>MARVIN WADLER</i>		22d. ADDRESS <i>8218 Wisconsin Ave., Bethesda, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>1</i>		23b. DATE THEREOF <i>12-22-66</i>	
23c. NAME OF CEMETERY OR CREMATORIALy <i>Lincoln Memorial.,</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Md.</i>	
24. FUNERAL DIRECTOR <i>Kirk &amp; Son</i>		25a. ADDRESS <i>Rockville, Md.</i>	25b. REC'D BY REGISTRAR DATE <i>DEC 27 1966</i>
		25c. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	



Items 18&21 Film 385 1-26 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE  
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PHM3. Page 5 may be retained for your files.

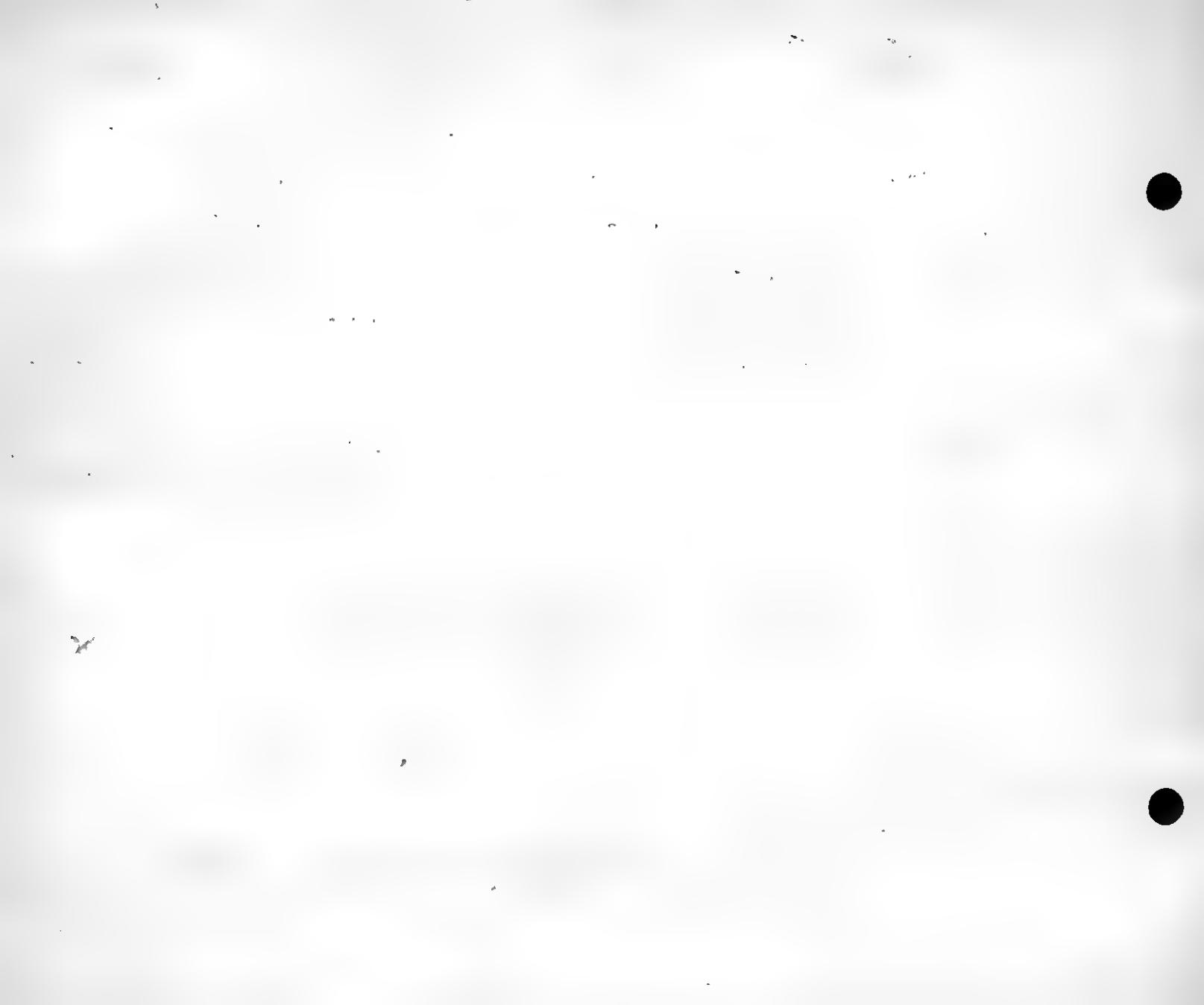
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit and in any event within 72 hours after death. Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17350

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17341

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		b. COUNTY <b>MONTGOMERY</b>	
c. LENGTH OF STAY IN lb <b>4 hrs, 5 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARIUM - Hospital</b>		d. STREET ADDRESS <b>7806 Wildwood Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Tobia</b>	Middle <b>HONORABLE</b>	Last <b>DiSILVESTRE</b>
4. DATE OF DEATH Month <b>DECEMBER</b>	Month <b>5</b>	Day <b>19</b>	Year <b>66</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <b>12-28-1900</b>	9. AGE (In years last birthday) <b>65 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR - Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Salvage Const. Co.</b>	11. BIRTHPLACE (State or foreign country) <b>ITALY</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. Amer.</b>
13. FATHER'S NAME <b>? Anthony DiSilvestre</b>	14. MOTHER'S MAIDEN NAME <b>? Phyllis DiMatteo</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) If yes give war or dates of service <b>No</b>	16. SOCIAL SECURITY NO <b>579-10-3890</b>	17. INFORMANT <b>Constance E. DiSilvestre</b>	Address <b>Same as # 2</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Shock due to gangrenous colonic bowel</b> DUE TO <b>570-7</b>	INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>obstruction and occlusive thrombosis.</b>	(b) <b>obstruction and occlusive thrombosis.</b> DUE TO	(c) <b>right common iliac artery.</b> DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Kilgore</i>	CHIEF MEDICAL EXAMINER <b>M.D.</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED <b>Dec. 6, 1966</b>
EXAMINER'S NAME (Type) <b>BELDEN R. KILGORE M.D.</b>	DEPUTY MEDICAL EXAMINER Address (Street, City, Town, or County)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 9, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Port Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Md.</b>
24. FUNERAL DIRECTOR <b>John B. Thomas</b>	ADDRESS <b>8434 Georgia Ave.</b>	25a. RECD BY REG STRAR <b>DEC 9</b>	25b. REG STRAR'S SIGNATURE <b>Charles Judge</b>
VR ATSMC 6M 1/66	Silver Spring, Md.		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23b Film G584 12/21/66 mh

17351

## CERTIFICATE OF DEATH

17342

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY <b>MONTGOMERY COUNTY MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING, MD</b>		c. LENGTH OF STAY IN b. <b>15 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>THE COLONIAL VILLA, HAMPSHIRE 1232 NEW</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C.</b>	
3 NAME OF DECEASED (Type or print) <b>RAPHAEL LOUIS DONDERO</b>		d. STREET ADDRESS <b>NE. WASHINGTON, D.C.</b>	
4 DATE OF DEATH <b>DECEMBER 15 1966</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>		f. COLOR OR RACE <b>White</b>	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		g. DATE OF BIRTH <b>March 28/12/82</b>	
10a. JEWISH OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. SALESMAN</b>		9. AGE (In years last birthday) <b>84 yrs</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BARTHOLOMEW DONDERO</b>		14. MOTHER'S MAIDEN NAME <b>MARY Retrella</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service <b>NO None</b>		16. SOCIAL SECURITY NO <b>577-10-5864</b>	
17. INFORMANT <b>Raphael J. Dondero</b>		18. ADDRESS <b>5602 2nd Avenue Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>527.1</b> DUE TO <b>Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Heart Failure</b> DUE TO <b>Heart Failure</b> (c) <b>Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/14/66</b> to <b>12/14/66</b> , that (I) (we) last saw the deceased alive on <b>12/14/66</b> , and that death occurred at <b>527.1</b> , from causes and on the date stated above.		22a. SIGNATURE <b>R. H. Sandstro</b>	
22b. DATE SIGNED <b>12/14/66</b>		22c. PHYSICIAN'S NAME (Type) <b>R. H. Sandstro</b>	
22d. ADDRESS <b>7701 Carrollton St. Silver Spring, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>Dec. 17, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Md.</b>		24. FUNERAL DIRECTOR <b>Clark E. Morris</b>	
25a. ADDRESS <b>8434 Georgia Ave., Silver Spring, Md.</b>		25b. REC'D BY REGISTRAR <b>DEC 19 1966</b>	
25c. DATE <b>DEC 19 1966</b>		25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17352

## CERTIFICATE OF DEATH

17343

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dpt. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	c. LENGTH OF STAY IN lb <i>6 days.</i>	b. COUNTY <i>Montgomery</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>616 Gist Ave.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Mary</i>	First <i>S.</i>	Middle <i>Julin</i>	4. DATE OF DEATH Month <i>Dec.</i> Day <i>9</i> Year <i>1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>ISAAC NEWTON BUSH HONG</i>	14. MOTHER'S MARIEN NAME <i>SOMERVILLE HAWKINS.</i>	Address <i>616 GIST AVE SILVER SPR-</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO	17. INFORMANT <i>Mrs CHARLES G TAYLOR.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart failure - uremia</i> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerotic cardiovascular disease (c) DUE TO Years		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>12/11/1966</i> to <i>12/18/1966</i> , that (I) (we) last saw the deceased alive on <i>12/8/1966</i> , and that death occurred at <i>2:44 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>James R Coleman MD</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>JAMES R. COLEMAN</i>	22d. ADDRESS <i>9241 COLUMBIA BLVD SILVER SPRING MD</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Dec. 12-1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Washington National</i>	23d. LOCATION (City or Town) (County) (State) <i>Bethesda Rd. Bethesda Md.</i>
24. FUNERAL DIRECTOR/ <i>Arthur Walters</i>	ADDRESS <i>254 Carroll St.</i>	25e. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15 (4) 20 M 1/66	DATE <i>DEC 14 1966</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17353

CERTIFICATE OF DEATH

17344

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Kings George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>i 2325 New Hampshire Ave</b>		c. LENGTH OF STAY IN b <b>11-2-66 to 12-4-66</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Int. Rainier</b>		f. STREET ADDRESS <b>3330 Chillum Rd., Apt. 202</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Colonial Villa Nursing Home</b>				g. DATE OF DEATH Month <b>Dec</b>		h. DAY <b>14</b>	
3 NAME OF DECEASED (Type or print) <b>Clara Maude Dunn</b>		First Middle Last		Month <b>Dec</b>		Year <b>1966</b>	
4. DATE OF DEATH Month <b>Dec</b>		Day <b>14</b>		IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS Days <b>0</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <b>11-5-74</b>	
9. AGE (In years last birthday) <b>92 yrs</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>HENRY FERRIS</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA MARMADUKE</b>		Address <b>10708 MARGATIS RD SILVER SPRING, MD.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS DORIS F. HARDY</b>		INTERV. BETWEEN ONSET AND DEATH <b>4 days</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>33IX</b>		DUE TO <b>Bronchopneumonia.</b>		DUE TO <b>Congestive Heart Failure</b>		DUE TO <b>CVA</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b></b>						<b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or Town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>11-2-66</b> to <b>12-4-66</b> , that (1) (we) last saw the deceased alive on <b>12-4-66</b> , and that death occurred at <b>2 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>R. H. Sandstrom</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>R. H. Sandstrom M.D.</b>		22d. ADDRESS <b>7701 Carroll Ave, Takoma Park, Md.</b>		22e. DATE SIGNED <b>12-4-66</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6 DEC 1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>ROCK CREEK CEM WASHINGTON, D.C.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>W.W. Chambers Jr., Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial/cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**17356****CERTIFICATE OF DEATH****17345****1. PLACE OF DEATH  
a. COUNTY****Montgomery****MARYLAND**

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

**Rockville**

c. LENGTH OF STAY IN 1b

**1 day**

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

**Potomac Valley Nursing Home****3. NAME OF  
DECEASED  
(Type or print)****First****Middle****Last****4. DATE  
OF  
DEATH****Month****Day****Year****George****Russell****Earl****Dec. 10****1966****5. SEX****6. COLOR OR RACE****7. MARRIED**  **NEVER MARRIED** **8. DATE OF BIRTH****9. AGE (In years  
last birthday)****10. UNDERS 1 YEAR****11. UNDERS 24 HRS.****Male****White****WIOOWED****OIVORSED****March 24, 1888****78 yrs.****Months****Days****Hours****Min.****10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)****10b. KIND OF BUSINESS OR  
INDUSTRY****11. BIRTHPLACE (County & State, or foreign country)****12. CITIZEN OF WHAT  
COUNTRY?****Painter****Navy Dept.****Detroit, Mich.****USA****13. FATHER'S NAME****George Earl****14. MOTHER'S MAIDEN NAME****Matilda Furgeson****15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)****16. SOCIAL SECURITY NO.****17. INFORMANT****Address****Yes****W.W. I****None****Mrs Essie S. Earl, Item 2****18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)****PART I. DEATH WAS CAUSED BY: Advanced Arteriosclerotic Cardio-vascular-renal****IMMEDIATE CAUSE (a)****Conditions, If any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.****DOUE TO****(b)****DUE TO****(c)****DUE TO****INTERVAL BETWEEN  
ONSET AND DEATH****5 years****Disease with Cerebral Thrombosis and Left Hemiplegia 1 MO.****(Nov. 10, 1966)****PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)****19. WAS AUTOPSY  
PERFORMED?****YES**  **NO** **20a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)****20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)****20c. TIME OF INJURY Month, Day, Year****20d. INJURY OCCURRED****20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)****20f. (City or town)****(County)****(State)****Hour****a.m.****p.m.****While  
at work****Not While  
at work****19****21. I certify that (I) (this hospital) attended the deceased from October 19, 1966, to December 10 1966, that (I) (we) last****saw the deceased alive on December 9, 1966, and that death occurred at 4:50 P.M. From the causes and on the date stated above.****22a. SIGNATURE***M. McKendree Boyer, M.D.***ATTENDING  
PHYS.****MED.  
DIRECTOR****STAFF  
PHYS.****December 10, 1966****DATE SIGNED****22c. PHYSICIAN'S  
NAME (Type)****22d. ADDRESS****9701 Church Street****66****Damascus, Maryland,****23a. BURIAL, CREMATION, REMOVAL (Specify)****23b. DATE THEREOF****23c. NAME OF CEMETERY OR CREMATORIUM****23d. LOCATION (City, town or county)****(State)****Burial****Dec 13, 1966****Monocacy****Reallsville, Md.****24. FUNERAL DIRECTOR****ADDRESS****25a. REC'D BY REGISTRAR****25b. REGISTRAR'S SIGNATURE***Olin L. Molesworth, Damascus, Md.***DATE****DEC 13 1966***Charles Judge*



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DENT.

17355

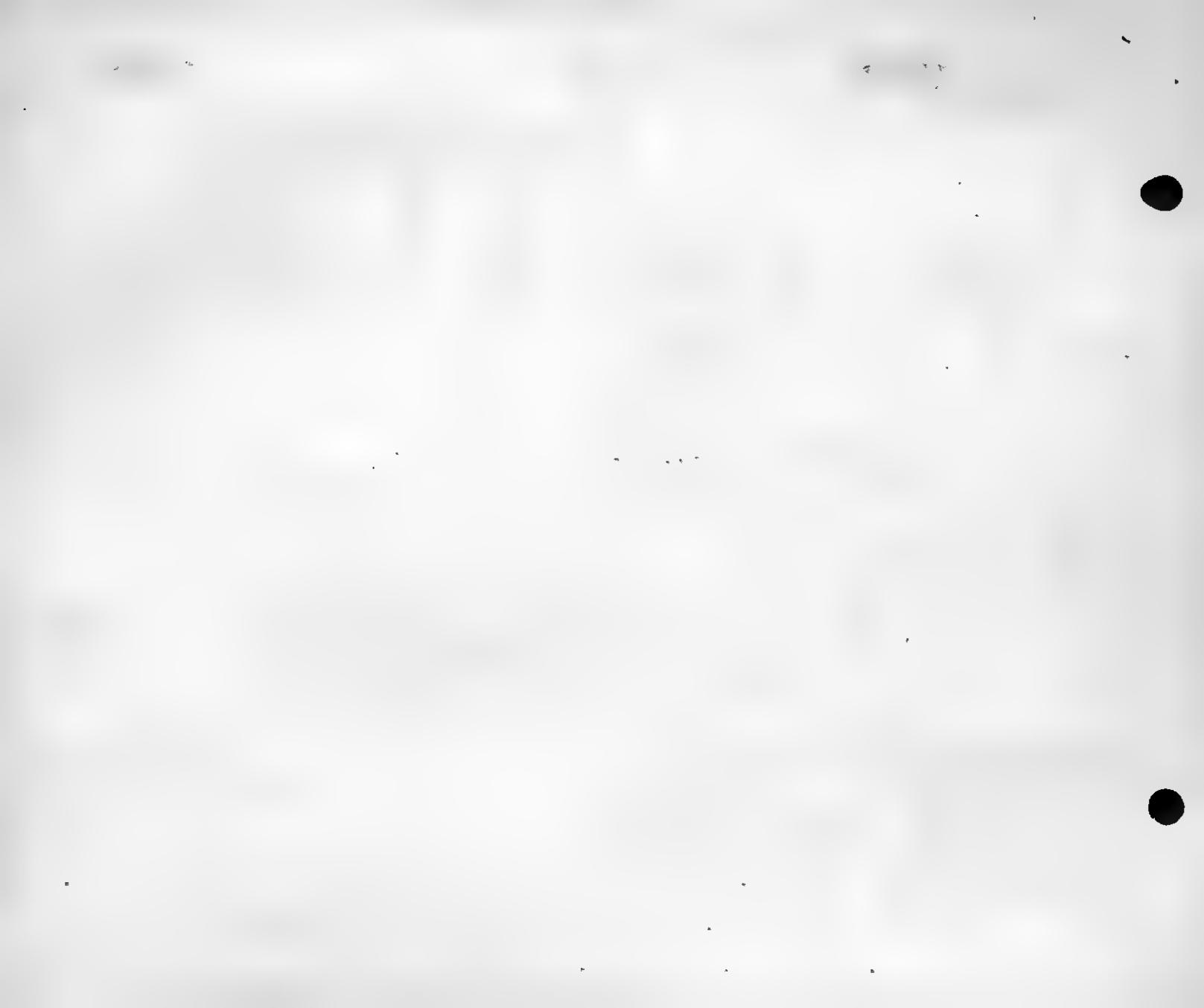
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17346

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return to the funeral director. Page 4 may be retained for your files.

1 PLACE OF DEATH a COUNTY <i>Mont. Co.</i>		2 USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) a STATE <i>Md.</i>				
b CITY OR TOWN (Outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c LENGTH OF STAY IN lb <i>5 days.</i>	c CITY OR TOWN (Outside corporate limits write RURAL and give nearest town) <i>Fairfield</i>	d STREET ADDRESS <i>6445 Acacia</i>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Sherburne</i>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Hagmar Irene Elliott</i>	First Middle Last	4 DATE OF DEATH Month Day Year <i>Dec. 5 1966</i>				
5. SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <i>7-2-21</i>	9 AGE (In years last birthday) yrs. <i>45</i>	10 UNDER 1 YEAR Months Days	11 UNDER 24 HRS Hours Min
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>California</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Louis More</i>		14. MOTHER'S MAIDEN NAME <i>Dagmar Finne</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO. <i>546-36-8914</i>		17. INFORMANT <i>Wendell E. Elliott</i>	Address <i>5445 Acacia</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Cirrhosis; esophageal varices with hemorrhage</i>		DUE TO (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cirrhosis; esophageal varices with hemorrhage</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						22. DATE SIGNED <i>12/6/66</i>
ACTUAL SIGNATURE <i>John G. Ball</i>	MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-transit</i>	23b. DATE THEREOF <i>12-7-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Fairfield Cemetery</i>		23d. LOCATION (City or Town) <i>Fairfield, California</i>	(County) (State)	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	ADDRESS	25a. RECEIVED BY REGISTRAR DATE <i>DEC 9 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



X  
8

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17356

CERTIFICATE OF DEATH

17347

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach to above carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 4, within 72 hours after death.

MEDICAL EXAMINER NOTIFIED/G.M.

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>OSKARS</b>		First <b>ELSTINS</b>	Middle <b>INN</b>
4 DATE OF DEATH <b>Dec. 21 1966</b>		Month <b>Dec.</b>	Day Year <b>21 1966</b>
S SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Feb 8 1902</b>		9 AGE (In years last birthday) <b>64 yrs</b>	10 IF UNDER 1 YEAR Months <b>0</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARP TEACHER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>	11 BIRTHPLACE (County & State, or foreign country) <b>LATVIA</b>
13 FATHER'S NAME <b>JANIS ELSTINS</b>		14. MOTHER'S MAIDEN NAME <b>CHRISTINA (Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>214-30-2109</b>	17. INFORMANT <b>ROTA HAJKOWSKI</b>
		Address <b>TAKOMA PK, MD. 636 HOUSTON AVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>420.1</b>			
DUE TO <b>Myocardial Infarction</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <b>Colonary Thrombosis</b>			
(c) <b>Coronary Arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Rockville</b>		(County) (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>21/11/1958</b> to <b>12/21/1966</b> that (I) (we) last saw the deceased alive on <b>12/17/1966</b> , and that death occurred at <b>9:00 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Stephen N. Jones</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22b. DATE SIGNED <b>12/21/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>		22d. ADDRESS <b>809 Viers Mill Road Rockville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 24, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Creek Cemetery</b>
23d. LOCATION (City or Town) <b>Washington, D. C.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>John B. Thomas - Tel. 427-8431 Georgia Ave.</b>		ADDRESS <b>8431 Georgia Ave.</b>	25a. RECD BY REGISTRAR DATE <b>ULU L. 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>W</b>



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17357

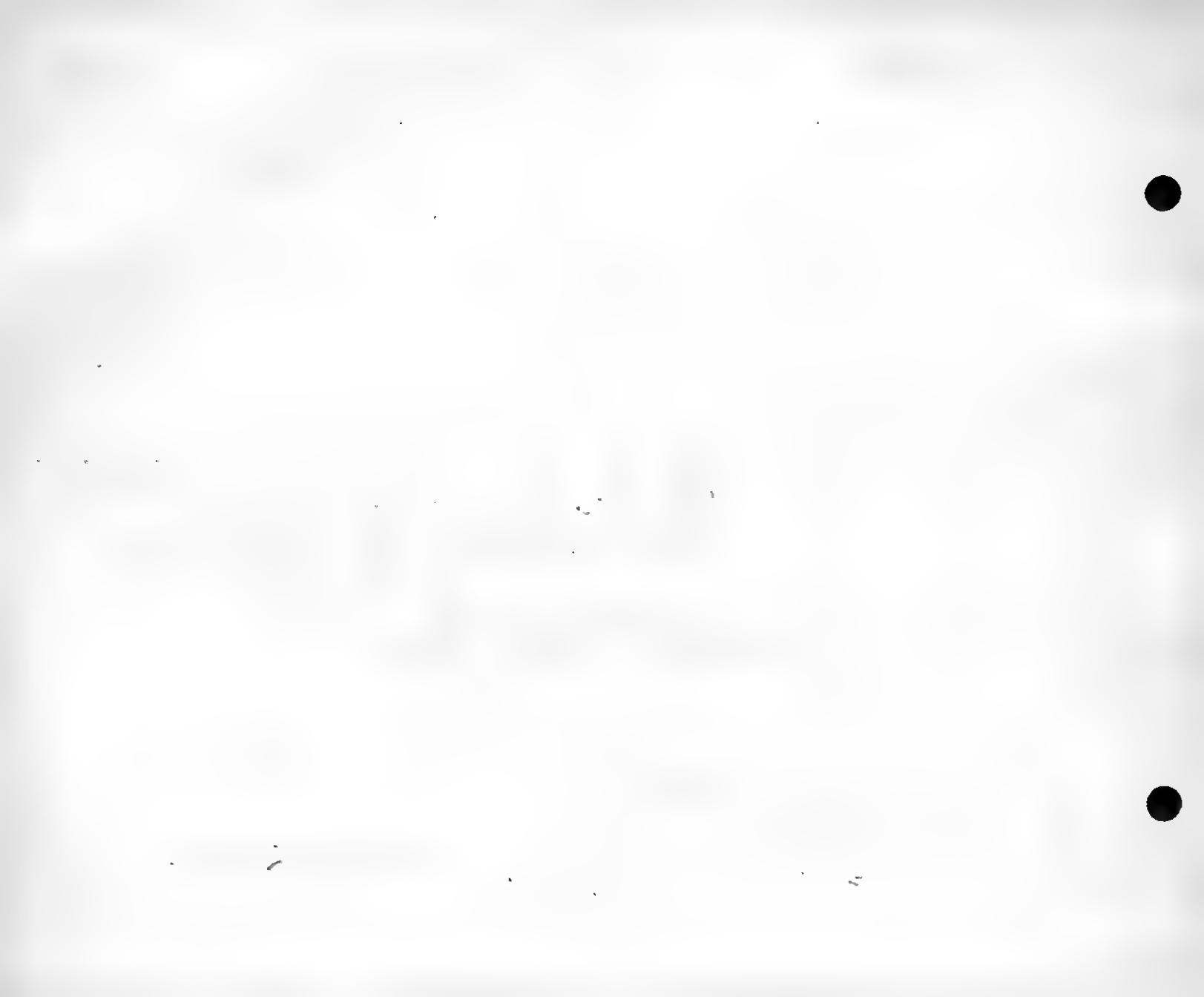
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17348

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN b. <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>2509 Spencer Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <b>Lucia</b>	Middle <b>DePabdo</b>	Last <b>Enrico</b>
4 DATE OF DEATH	Month <b>December</b>	Day <b>15</b>	Year <b>1966</b>
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH <b>4/10/92</b>	9 AGE (in years last birthday) <b>74</b> yrs	10 IF UNDER 1 YEAR Months <b>0</b>	11 IF UNDER 24 HRS Days <b>0</b>
10b USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Housewife</b>	10b KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11 BIRTHPLACE (State or foreign country) <b>Lucca, Italy</b>	12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13 FATHER'S NAME <b>Lazaro Ferrari</b>	14 MOTHER'S MAIDEN NAME <b>Katherine Ferrari</b>	15. INFORMANT Daughter, Address <b>Anna Williams 2509 Spencer Rd. Sil.Spr.Md.</b>	
16 SOCIAL SECURITY NO <b>None</b>	17. INFORMANT Daughter, Address <b>Anna Williams 2509 Spencer Rd. Sil.Spr.Md.</b>	18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Coronary Artery Heart Disease.</b>	
19 INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>J. Belden Reap</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED <b>Dec. 15, 1966</b>
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, City, Town, or County) <b>Clark E. Wisor</b>			
23a. BURIAL... CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 19, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>
24. FUNERAL DIRECTOR <b>Clark E. Wisor</b>	ADDRESS <b>8434 Georgia Ave.</b>	REG'D BY REG STRR <b>DEC 21 1966</b>	25b. REGISTRAR'S SIGNATURE <b>11</b>
Clark E. Wisor Warren L. Humphrey, Inc.		Silver Spring, Md.	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17358

CERTIFICATE OF DEATH

17349

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut or Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Suburban</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>9912 Silverbrook Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>B. Miller Evans</u>		4. DATE OF DEATH <u>Dec 27 1966</u>	
S SEX <u>m</u>	6 COLOR OR RACE <u>w</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/30/117</u>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 AGE (in years last birthday) <u>49 yrs</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if ret red) <u>Psychologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boardy Education</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Evans</u>		14. MOTHER'S MAIDEN NAME <u>Julia Thom</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Mary E. Evans</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal tubular disease, massive</u> DUE TO <u>16 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral edema</u> DUE TO <u>2 weeks</u>			
(c) <u>Bronchogenic carcinoma</u> DUE TO <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 16</u> , 1966, to <u>12-27</u> , 1966, that (I) (We) last saw the deceased alive on <u>12-16</u> , 1966, and that death occurred at <u>923A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Francis C Mayle Jr MD</u>			
22c. PHYSICIAN'S NAME (Type) <u>Francis C Mayle Jr MD</u>		22d. ADDRESS <u>8218 Wisconsin Ave Bethesda</u>	22b. DATE SIGNED <u>1/28/67</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>12-29-66</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>See Funeral Home</u>
23d. LOCATION (City or Town) <u>Wash. DC</u>		(County) <u></u> (State) <u></u>	
24. FUNERAL DIRECTOR <u>See Funeral Home</u>		25a. ADDRESS <u>300 4th St N.E. Wash DC</u>	25b. REC'D BY REGISTRAR <u>John J. 3</u>
		25c. DATE <u>Jan 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Evans</u>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17359

CERTIFICATE OF DEATH

17350

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. STREET ADDRESS <u>1951 Rosemary Hills Dr.</u>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Myriam F.</u>		First	Middle	Last	4. DATE OF DEATH Month <u>Dec.</u> Day <u>27</u> Year <u>1966</u>	Month	Day	Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/29/29</u>	9. AGE (In years last birthday) <u>37 yrs</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS Days <u>0</u>	12. IF UNDER 24 MINS Hours <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assemble small electronics devices</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C. E. I. INDUSTRY</u>		11. BIRTHPLACE (Country & State, or Foreign country) <u>Costa Rica</u>		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <u>Manuel Freer</u>		14. MOTHER'S MAIDEN NAME <u>Lia Jimenez</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Adolfo Fabrega same as #2</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto Injuries</u>		DUE TO <u>5810</u>		DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>47 hours</u>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or Town) <u>San Jose</u>	(County) <u>Costa Rica</u>	(State) <u>Costa Rica</u>
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1, 1966</u> , to <u>Dec. 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec. 1, 1966</u> , and that death occurred at <u>11 AM</u> , from causes and on the date stated above.				22a. SIGNATURE <u>Aaron H. Traum</u>		22b. DATE SIGNED <u>Dec. 11, 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>		22d. ADDRESS <u>8237 Costa Rica Ave. Silver Spring, MD 20901</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE THEREOF <u>12/29/66</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>General Cemetery</u>		23d. LOCATION (City or Town) <u>San Jose</u>		(County) <u>Costa Rica</u>		(State) <u>Costa Rica</u>	
24. FUNERAL DIRECTOR <u>S.H. Hines Co. Wash. D.C.</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>JAN 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John Judge</u>				



Items 20&21 Film 305 1-2 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17360

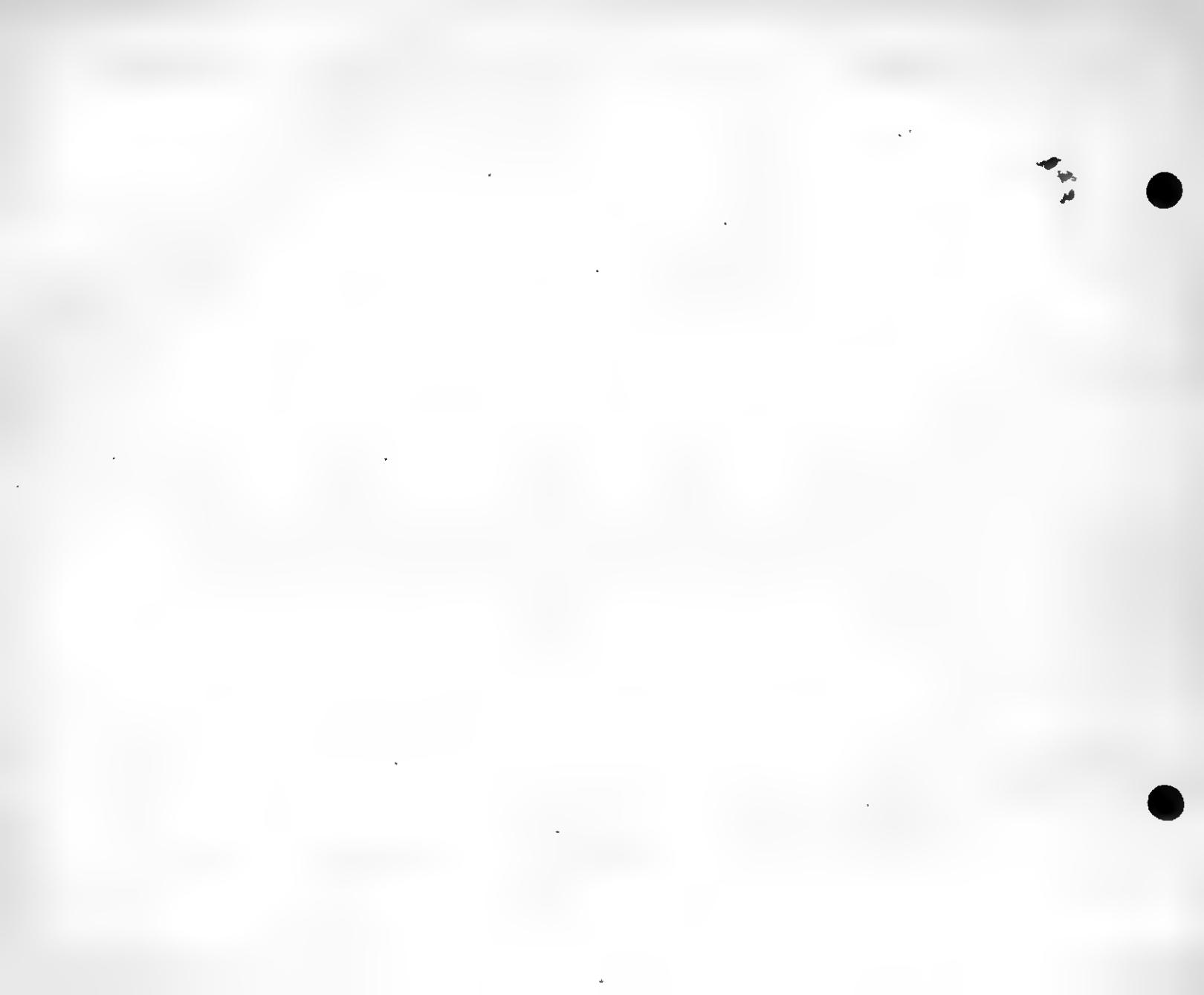
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17351

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Pencil between 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived if inst lnt on Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>2 hr., 15 min.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
3 NAME OF DECEASED (Type or print) <b>Clementine</b>		First <b>M.</b>	Middle <b>Ferger</b>
4 DATE OF DEATH <b>December 5, 1966</b>	Month <b>December</b>	Day <b>5</b>	Year <b>1966</b>
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH <b>May 16, 1890</b>	9 AGE (In years last birthday) <b>76</b>	10 UNDER 1 YEAR Months <b>0</b>	11 UNDER 24 HRS Days <b>0</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>	10b KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11 BIRTHPLACE (State or foreign country) <b>New York</b>	12 CITIZEN OF WHAT COUNTRY <b>USA</b>
13 FATHER'S NAME <b>Unknown</b>	14 MOTHER'S MAIDEN NAME <b>Unknown</b>	Address	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> or unknown) If yes give war or dates of service <b>No</b>	16 SOCIAL SECURITY NO <b>060-05-2586-A</b>	17 INFORMANT <b>Mrs. H. Sanders, Daughter, Same</b>	18 INTERVAL BETWEEN ONSET AND DEATH
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, <u>fracture</u> , which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
<u>Intrapertitoneal hemorrhage due to</u> <u>multiple pelvic fractures due</u> <u>to trauma</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) Deceased apparently jaywalking when struck by auto		
20c TIME OF INJURY Month, Day Year Hour <input type="checkbox"/> 5 : 35 p.m. Min <input type="checkbox"/> 12 5 1966	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Street	20f (City or Town) (County) (State) <b>Silver Spring Montg. Md.</b>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.	22. DATE SIGNED <b>Dec. 6, 1966</b>
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.	Address (Street, City, Town, or County) <i>Washington, D. C.</i>	
23a BURIAL, CREMATION, REMOVAL(SPECIFY) <b>Burial</b>	23b DATE THEREOF <b>Dec 8, 1966</b>	23c NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24 FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc</b>	ADDRESS <b>Washington, D. C.</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



FOR STATE  
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 -  
Item 3 Film G-14 1/3/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17352

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda.</i>		c. LENGTH OF STAY IN lb. <i>years.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7025 Strathmore St apt 4.</i>		e. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town) <i>Bethesda.</i>	
3. NAME OF DECEASED (Type or print) <i>Irene E. Finnigan</i>		First <i>Irene</i>	Middle <i>E.</i>
4. SEX <i>f.</i>	5. COLOR OR RACE <i>w.</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W.DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>2/14/1883</i>
8. DATE OF DEATH <i>Dec - 7 1966</i>		9. AGE (in years lost birthday) <i>83 yrs</i>	10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10b. KIND OF BUSINESS OR INDSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>
12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i>		13. FATHER'S NAME <i>Harry Helwig</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>—</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infarction, pain</i> DUE TO <i>—</i> INTERVAL BETWEEN ONSET AND DEATH <i>—</i> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Arteriosclerosis</i> Immediate (b) <i>—</i> DUE TO <i>—</i> (c) <i>—</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
20c. TIME OF INJURY Month, Day Year Hour a.m. <i>—</i> p.m. <i>19</i>		20d. INJRY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJRY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>John J. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <i>12/8/66</i>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-10-1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Rock Creek Cemetery</i>		23d. LOCATION (City or Town) <i>Washington, D.C.</i> (County) <i>—</i> (State) <i>—</i>	
24. FUNERAL DIRECTOR <i>Joseph Lawler's Sons Inc.</i>		25a. REC'D BY REG STAR <i>Charles Judge</i> ADDRESS <i>5130 Wisconsin Ave. N.W. Wash. D.C.</i> 25b. REG STAR'S SIGNATURE	
56 M 1/66		DATE DEC 14 1966	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

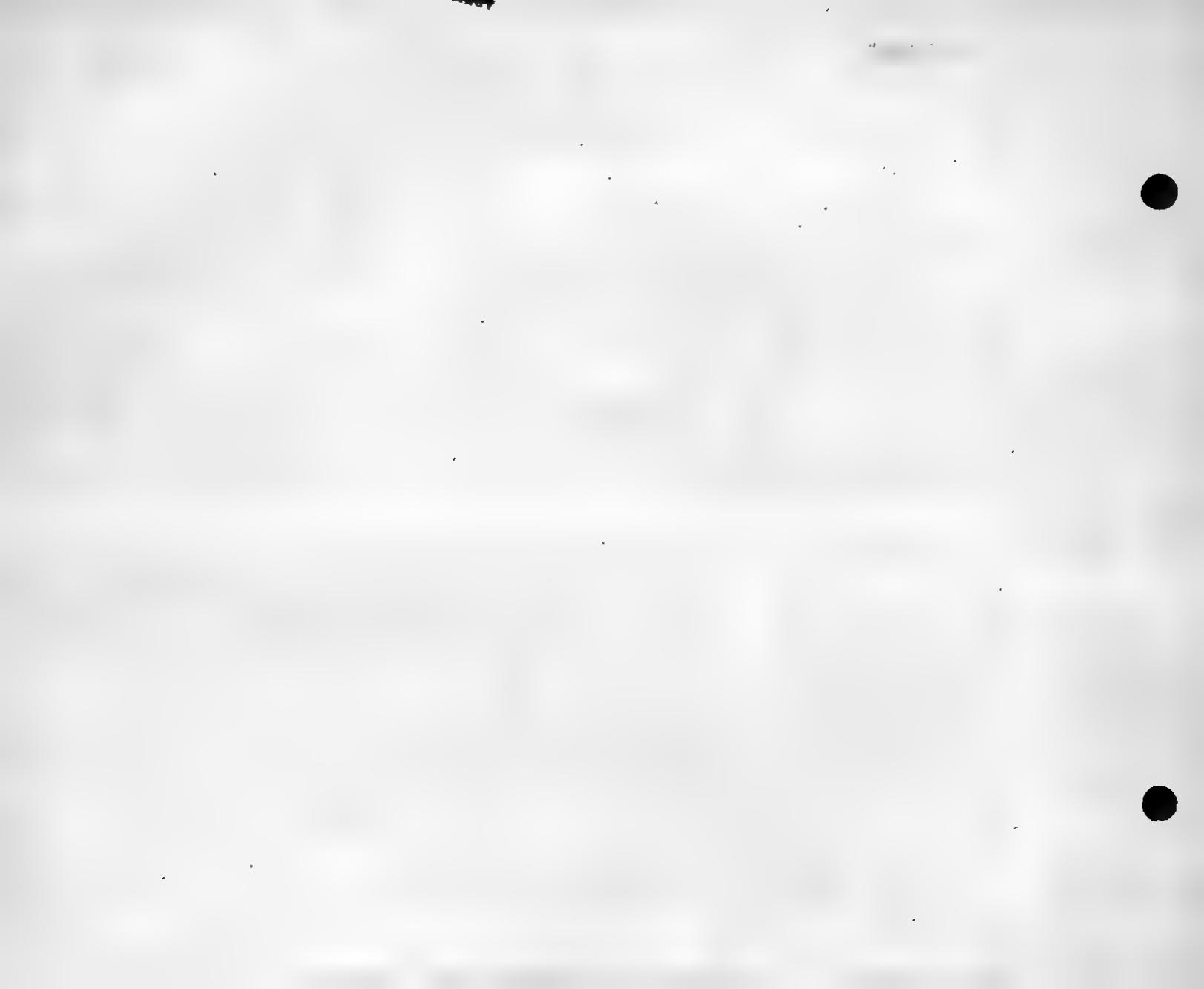
17362

## CERTIFICATE OF DEATH

17353

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.*Cleared with Dr. Robert Keay, Bethesda Hospital*

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring, Maryland</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>4 days.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring, Maryland</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>902 Cotten Drive</i>	
3. NAME OF DECEASED (Type or print) <i>William F. Fitzgerald</i>		4. DATE OF DEATH Month <i>12</i> Day <i>25</i> Year <i>1966</i>	
5. SEX <i>Male</i> COLOR OR RACE <i>white</i>		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>W.G. &amp; Co.</i>	
11. BIRTHPLACE (County & State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Fitzgerald</i>		14. MOTHER'S MAIDEN NAME <i>Julia Wrenn</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>yes. unk.</i>	
17. INFORMANT <i>Annie E. Fitzgerald</i>		Address <i>422</i>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Dissecting Aneurysm of Thoracic Aorta</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. <i>4571X</i>		YEARS	
(b) <i>due to Aortic Atherosclerosis</i>			
(c) <i>Atheroscleroticosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) <i>Arteriosclerosis</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>p.m.</i> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Bethesda</i> (County) <i>Montgomery</i> (State) <i>Maryland</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>12/25/66</i> , to <i>12/25/66</i> , 1966 that (I) (we) last saw the deceased alive on <i>12/25/66</i> , and that death occurred at <i>77</i> M, from causes and on the date stated above.			
22b. SIGNATURE <i>John J. Cleary</i>		22b. DATE SIGNED <i>12/25/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>John J. Cleary</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <i>10620 Georgia Ave Silver</i>			
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 29, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Olivet</i>		23d. LOCATION (City or town) <i>Bethesda</i> (County) <i>Montgomery</i> (State) <i>Maryland</i>	
24. FUNERAL DIRECTOR <i>W.W. Altman 3603 1/2 St NW</i>		25a. REC'D BY REGISTRAR <i>DEC 28 1966</i>	
ADDRESS <i>same as above</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17363

CERTIFICATE OF DEATH

17354

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>				
c. LENGTH OF STAY IN lb <i>1 mo.</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Congregational Hospital Bethesda, 9200 Rockville Pike, Bethesda</i>				d. STREET ADDRESS <i>10820 Georgia Avenue</i>				
3. NAME OF DECEASED (Type or print) <i>Laura</i>		First <i>-</i>	Middle <i>-</i>	Last <i>Foster</i>	4. DATE OF DEATH <i>Dec 11 1966</i>	Month <i>Dec</i>	Day <i>11</i> Year <i>1966</i>	
S. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 4 1890</i>	9. AGE (In years last birthday) <i>86 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>homemaker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>own Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Childress</i>				14. MOTHER'S MAIDEN NAME <i>Lydia Tinder</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO <i>579-44-4180</i>	17. INFORMANT <i>Wife + Husband</i>			
					Address <i>10820 Georgia Ave - apt 404, Wheaton, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>				
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic HD</i>				years <i>years</i>				
DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>10820 Georgia Ave</i>	20f. (City or town) <i>Rockville</i>	(County) <i>Montgomery</i>	(State) <i>Maryland</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Oct. 21, 1966, to Dec. 11, 1966</i> that (I) (we) last saw the deceased alive on <i>Dec. 10, 1966</i> and that death occurred at <i>10820 Georgia Ave</i> , from causes and on the date stated above.								
22a. SIGNATURE <i>G. Bowditch Hunter Jr.</i>				22b. DATE SIGNED <i>Dec. 11, 1966</i>				
22c. PHYSICIAN'S NAME (Type) <i>G. Bowditch Hunter, Jr.</i>				22d. ADDRESS <i>50 W. Edmonston Dr., Rockville</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 13, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) <i>Suitland, Maryland</i>			
24. FUNERAL DIRECTOR <i>John B. Thomas</i>		8035 Georgia Ave	250 REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
20 A15 (4) 20 M 1/66		Warner E. Pumphrey, Inc.	DEC 14 1956					



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17364 Item 2b Film G 314 CERTIFICATE OF DEATH

17355

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>	
f. STREET ADDRESS <i>4008 Cherokee St</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Raymond</i>	Middle <i>John</i>	Last <i>Frey</i>
4. DATE OF DEATH Month <i>Dec.</i>	Month <i>Dec.</i>	Day <i>9</i>	Year <i>1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-31-09</i>
9. AGE (In years 1st birthday) <i>61 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		11. BIRTHPLACE (County & State or foreign country) <i>Michigan</i>
12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>		13. FATHER'S NAME <i>Harrison A. Frey</i>	
14. MOTHER'S MAIDEN NAME <i>Gulian Tully</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give war or date of service <i>Yes W.W.II</i>	
16. SOCIAL SECURITY NO. <i>334240541</i>		17. INFORMANT Address <i>Wife- Estelle G. Fry Same as #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction, massive</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause <i>420.11</i> (b) <i>Coronary arteriosclerosis</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bronchogenic carcinoma with widespread metastasis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Dec 7, 1966, to Dec 8, 1966</i>
20f. (City or town) <i>Dec 8, 1966</i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 7, 1966</i> , to <i>Dec 8, 1966</i> that (I) (we) last saw the deceased alive on <i>Dec 8, 1966</i> and that death occurred at <i>6:30 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>V. de Gurmán MD</i>		22b. DATE SIGNED <i>12-9-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>V. de Gurmán MD</i>		22d. ADDRESS <i>123X 19 NW WASH. D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12 Dec 1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>George Washington Cemetery</i>
24. FUNERAL DIRECTOR <i>W.W. Chambers 800 Riverdale, Md.</i>		ADDRESS <i>W.W. Chambers 800 Riverdale, Md.</i>	25. RECEIVED BY REGISTRAR DATE <i>DEC 12 1966</i>
26. REGISTRAR'S SIGNATURE <i>James J. ...</i>		27. REGISTRAR'S SIGNATURE <i>James J. ...</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17365

CERTIFICATE OF DEATH

17356

**10. HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**11. FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>16</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>901 Arcola Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. NAME OF DECEASED (Type or print) <i>Isaac</i>		First <i>Samuel</i>	Middle <i>Gadol</i>
g. SEX <i>Male</i>		h. COLOR OR RACE <i>White</i>	i. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
j. DO USA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pharmacist</i>		k. KIND OF BUSINESS OR INDUSTRY	
l. FATHER'S NAME <i>Samuel Gadol</i>		m. BIRTHPLACE (County & State, or foreign country) <i>Roumania</i>	
n. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		o. SOCIAL SECURITY NO.	
p. INFORMANT		q. Address <i>Sol Gadol 4501 Conn. Ave., NW... D.C.</i>	
r. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first <i>arteriosclerosis</i>		s. INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
(b) DUE TO <i>arteriosclerosis</i>		(c) DUE TO <i>heart disease</i>	
t. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <i>Emphysema</i>		u. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
v. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		w. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>external chest massage</i>	
x. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		y. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
z. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		aa. (City or town) (County) (State)	
bb. I certify that (I) (his hospital) attended the deceased from <i>12-27-66</i> to <i>12-28-66</i> that (I) (we) last saw the deceased alive on <i>12-28-66</i> , and that death occurred at <i>4201</i> M, from causes and on the date stated above.		cc. DATE SIGNED <i>12-28-66</i>	
dd. SIGNATURE <i>John Jepson</i>		ee. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> ff. ADDRESS <i>800 PERSHING DRIVE</i>	
gg. PHYSICIAN'S NAME (Type) <i>JASON GEIGER M.D.</i>		hh. LOCATION (City or Town) (County) (State) <i>FALLS CHURCH VA</i>	
ii. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		jj. DATE THEREOF <i>12-30-66</i>	
kk. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>KING DAVID MEMORIAL GARDEN</i>		ll. LOCATION (City or Town) (County) (State) <i>SILVER SPRING MD</i>	
mm. FUNERAL DIRECTOR <i>BERNARD DANZANSKY &amp; SONS - WASHINGTON DC</i>		nn. REC'D BY REGISTRAR <i>JAN 3 1967</i>	
oo. REGISTRAR'S SIGNATURE <i>Judge</i>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

ITEMS 13, 14 RIM G384 1/3/67 PH

17366

## **CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

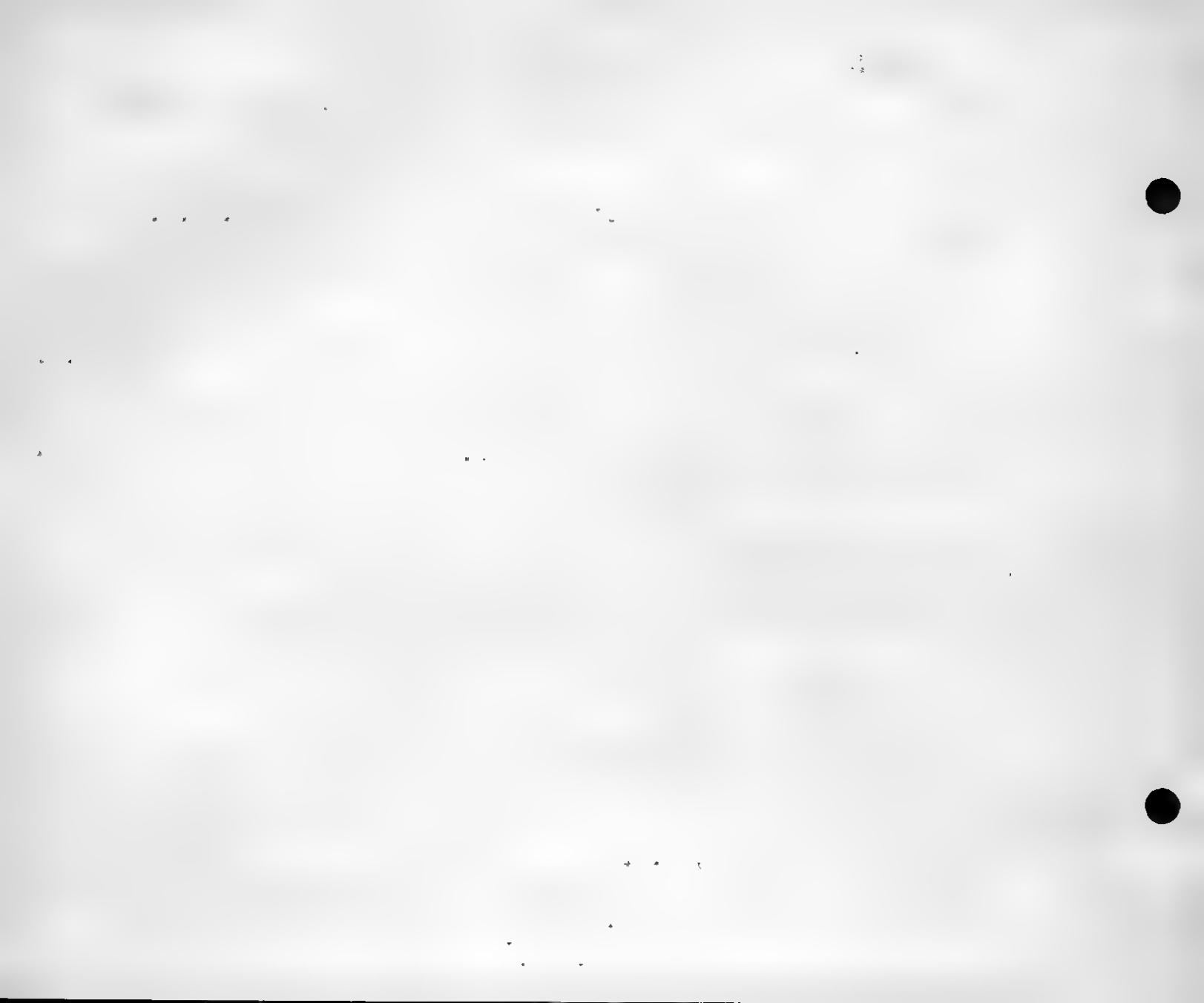
**NO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coronavirus test failed & will approve

1 PLACE OF DEATH a COUNTY		MONTGOMERY		2 USUAL RESIDENCE (Where deceased lived, if institution, Reside before or after admission)	
b CITY OR TOWN (If outside corporate limits, give street address, nearest town)		c LENGTH OF STAY IN机构		d CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
BETHESDA				WASHINGTON	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
BETHESDA-SILVER SPRING NURSING HOME		5250 LINNEAN AVE. N.W.			
3 NAME OF DECEASED (Type or print)		First	Middle	4 DATE OF DEATH	Month Day Year
Adam			Garofalo	12 - 11	1966
S. SEX	6. COLOR OR RACE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH	9 AGE (In years last birthday) 83 yrs	IF UNDER 1 YEAR Months Days Hours Min.
M	W		8-4-83		
10a. USUAL OCCUPATION (Give kind of work done during day or month before retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
BRICKLAYER		CONSTRUCTION		ITALY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY U.S.A.	
Vitangelo Garofalo		Maria Assunta Delguidice			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
				MRS. JOSEPH GOLDMAN ( SAME AS SEC. 2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY.		INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) 334X		3 yrs			
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-11-66</u> to <u>12-11-66</u> , that (I) (we) last saw the deceased alive on <u>10-30-66</u> , and that death occurred at <u>1A</u> M, from causes and on the date stated above				20f. (City or town) (County) (State)	
22a. SIGNATURE		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22b. DATE SIGNED	
LOUIS ROSS, M.D.		1712 Eye St. N.W. Wash. D.C.		12-11-66	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. LOCATION (City or Town) (County) (State)	
Burial		12/12/1966		Bladensburg, Md	
24. FUNERAL DIRECTOR		Ft. Lincoln		25a. REC'D BY REGISTRAR	
Josiah W. Anderson		ADDRESS WASH. DC 5130 Wisc. Ave. NW		DEC 19 1966	
				25b. REGISTRAR'S SIGNATURE	
				Charles Judge	

VR A15 (4)  
20 M 1/66

2



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

**17367**

**17358**

**1. PLACE OF DEATH**

**b. COUNTY**

*Montgomery*

**b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)**

*Bethesda*

**d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)**

*9200 Old Georgetown Rd.*

**MARYLAND**

**c. LENGTH OF STAY IN lb**

*6 yrs*

**2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)**

**a. STATE**

*Virginia*

**b. COUNTY**

*Sherandoah*

**c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)**

*New Market*

**e. IS RESIDENCE ON A FARM?**

**YES  NO**

**3. INDIVIDUAL DECEASED  
(Type or print)**

**First**

**Middle**

**Last**

*MOSE*

*FRANK*

*Getz*

**4. DATE OF DEATH**

**Month**

**Day**

**Year**

*Dec.*

*1*

*1966*

**5. SEX**

*M*

**6. COLOR OR RACE**

*Sh*

**7. MARRIED  NEVER MARRIED**

**WIDOWED**

**DIVORCED**

**8. DATE OF BIRTH**

*Sept. 8, 1874*

**9. AGE (In years last birthday)**

*92 yrs.*

**IF UNDER 1 YEAR**

**Months**

**IF UNDER 24 HRS.**

**Days**

**Hours**

**Min.**

**10a. OCCUPATION (Give kind of work done during most of working life, even if retired)**

*Farmer*

**13. FATHER'S NAME**

*Unobtainable*

**10b. KIND OF BUSINESS OR INDUSTRY**

**11. BIRTHPLACE (County & State or foreign country)**

*Shevandoah, Virginia*

**12. CITIZEN OF WHAT COUNTRY?**

*U.S.*

**14. MOTHER'S MAIDEN NAME**

*Leannah Bowers*

**Address**

*9390 Old Georgetown Rd.  
Bethesda, Md.*

**INTERVAL BETWEEN  
ONSET AND DEATH**

**YEARS**

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)**

*No*

**16. SOCIAL SECURITY NO.**

**17. INFORMANT**

**Goldie G. Rogers**

**Address**

*9390 Old Georgetown Rd.  
Bethesda, Md.*

**18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)**

**PART I. DEATH WAS CAUSED BY:**

**IMMEDIATE CAUSE (a)**

*Arteriosclerotic*

**DUE TO**

**Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause first. (b)**

**DUE TO**

**cause last. (c)**

*arteriosclerotic cardio vascular dis.*

**INTERVAL BETWEEN  
ONSET AND DEATH**

**YEARS**

**MEDICAL CERTIFICATION**

**20e. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)**

**20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)**

**20c. TIME OF INJURY Month, Day, Year**  
Hour e.m.  
p.m.                    19

**20d. INJURY OCCURRED**  
While Not While  
at work  at work

**20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)**

**20f. (City or town)**  
**(County)**  
**(State)**

**21. I certify that (I) (this hospital) attended the deceased from ..... to ..... that (I) (we) last saw the deceased alive on .....**

**saw the deceased alive on .....** Nov. 25 1966, and that death occurred at ..... A.M., from the causes and on the date stated above.

**22e. SIGNATURE**

*Dewitt E. DeLawter*

**M.D.**

**ATTENDING  
PHYS.**

**MED.  
DIRECTOR**

**STAFF  
PHYS.**

**22b. DATE  
SIGNED**  
*12-1-66*

**22c. PHYSICIAN'S  
NAME (Type)**

*Dewitt E. DeLawter*

**22d. ADDRESS**

*8025 ABERDEEN RD. Bethesda, Md.*

**23e. BURIAL, CREMATION,  
REMOVAL (Specify)**

**23b. DATE THEREOF**

**23c. NAME OF CEMETERY OR CREMATORIUM**

**23d. LOCATION (City, town or county)**

**(State)**

*Salomon's Lutheran Cem. New Market, Va.*

**24 FUNERAL DIRECTOR'S SIGNATURE**

**ADDRESS**

**25e. REC'D BY REGISTRAR**

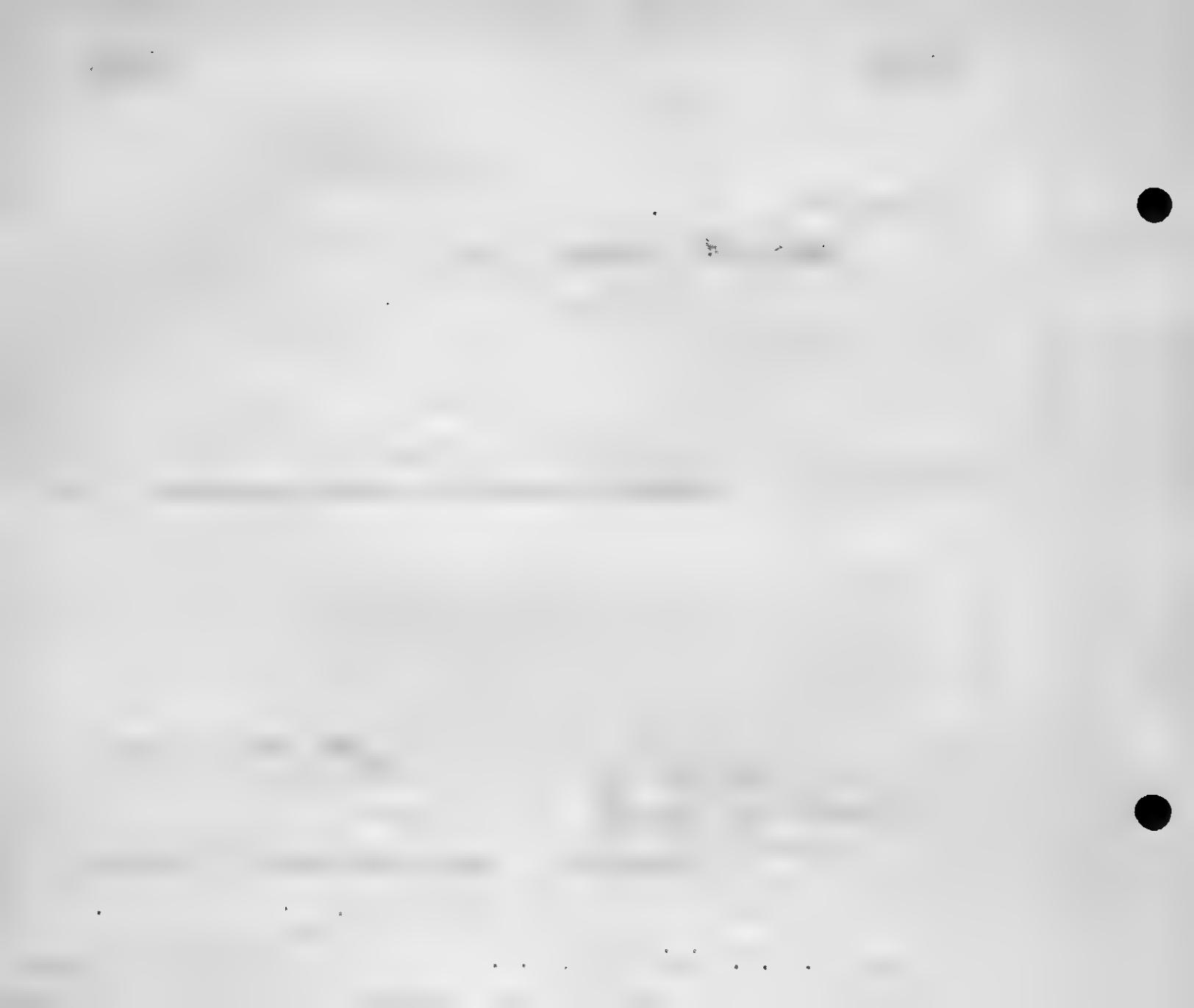
**25b. REGISTRAR'S SIGNATURE**

*The S.H. Hines Company  
2901 14th St. N.W. Washington, D.C.*

**DATE**

**DEC 2 1966**

*Charles Judge*



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

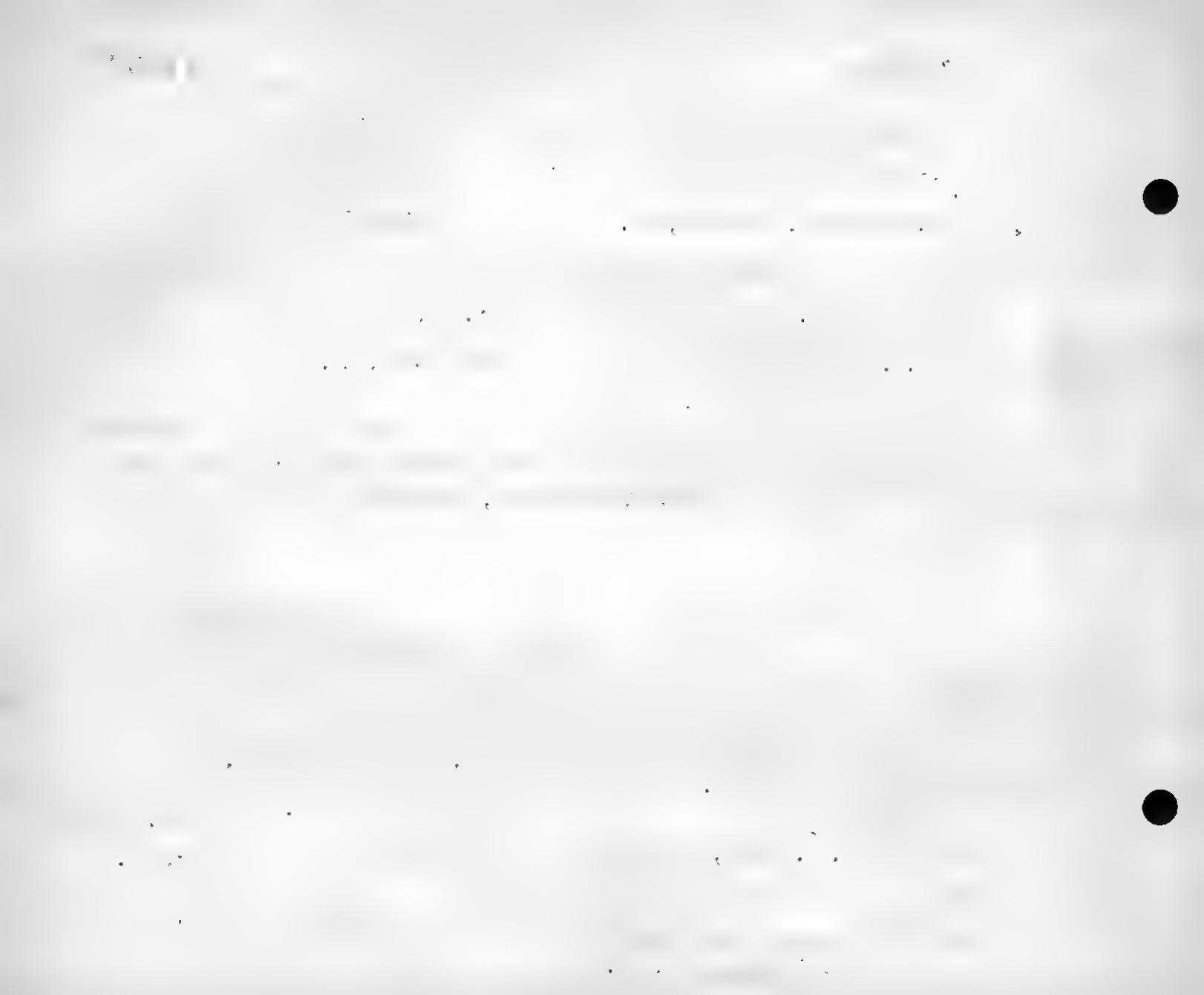
17368

## CERTIFICATE OF DEATH

17359

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Thereafter, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Bethesda (rural)</b>	c. LENGTH OF STAY IN fb <b>33 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b>	d. STREET ADDRESS <b>4 Riggs Road</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph Thomas GODFREY</b>	First <b>Joseph</b>	Middle <b>Thomas</b>	Last <b>GODFREY</b>
4. DATE OF DEATH <b>December 30</b>	Month <b>December</b>	Day <b>30</b>	Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. NEVER MARRIED <input checked="" type="checkbox"/>
9. B. DATE OF BIRTH <b>Apr. 28, 1920</b>	10. AGE (In years last birthday) <b>46 yrs</b>	11. IF UNDER 1 YEAR Months <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Newcom</b>	11. COUNTRY OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jos. T. Godfrey</b>	14. MOTHER'S MAIDEN NAME <b>Wabel Brooks</b>	15. ADDRESS <b>Maryland</b>	
16. SOCIAL SECURITY NO. <b>118-59-094</b>	17. INFORMANT <b>Severna Park</b>	18. Mrs. Virginia Godfrey, 4 Riggs Road	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHIAL PNEUMONIA, BILATERAL</b> DUE TO 191X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)			
20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Severna Park</b>		(County) <b>Maryland</b> (State) <b>MD</b>	
21. I certify that <b>(s)</b> (this hospital) attended the deceased from <b>Nov. 27</b> , 1966, to <b>Dec. 30</b> , 1966, that <b>(s)</b> (we) last saw the deceased alive on <b>Dec. 30</b> , 1966, and that death occurred at <b>1020 M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J. E. Davis</b>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/>	A.M. STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED <b>Dec. 31 1966</b>
22c. PHYSICIAN'S NAME (Type) <b>J. E. DAVIS, LT MC USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-4-67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>	23d. LOCATION (City or Town) <b>Baltimore, Md.</b> (County) <b>Baltimore</b> (State) <b>MD</b>
24. FUNERAL DIRECTOR <b>Severna Park Funeral Home, Severna Park, Md.</b>	25a. ADDRESS <b>118 Barrancas</b>	25b. REC'D BY REGISTRAR <b>JAN 4 1967</b>	25b. REGISTRAR'S SIGNATURE <b>W. J. Barranca</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 21 Film 3384 1/2/62 mh

17369

## CERTIFICATE OF DEATH

17360

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE <b>Maryland</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c LENGTH OF STAY IN lb <b>90 days</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
3. NAME OF DECEASED (Type or print) <b>Pearl</b>		First <b>(None)</b>	Middle <b>Gordon</b>
4. DATE OF DEATH <b>December 25 1966</b>		Month <b>December</b>	Doy Year <b>25 1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>26 December 1940</b>
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10c. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Rappaport</b>		14. MOTHER'S MAIDEN NAME <b>Sophie Abrams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-38-5889</b>	
17. INFORMANT <b>The Medical Records</b>		Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Malignant Melanoma - Generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>
21. I certify that (A) (this hospital) attended the deceased from <b>Sept. 26, 1966</b> to <b>Dec. 25, 1966</b> , that (B) (we) last saw the deceased alive on <b>25 December 1966</b> , and that death occurred at <b>12:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Leroy Fass, M.D.</i>		P.M.	
22c. PHYSICIAN'S NAME (Type) <b>Leroy Fass, M.D.</b>		22d. DATE SIGNED <b>12/25/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-29-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Arl. Natl. Cem.</b>
24. FUNERAL DIRECTOR <i>Goldberg Funeral Home</i>		25a. REC'D BY REGISTRAR DATE <b>DEC 28 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17370

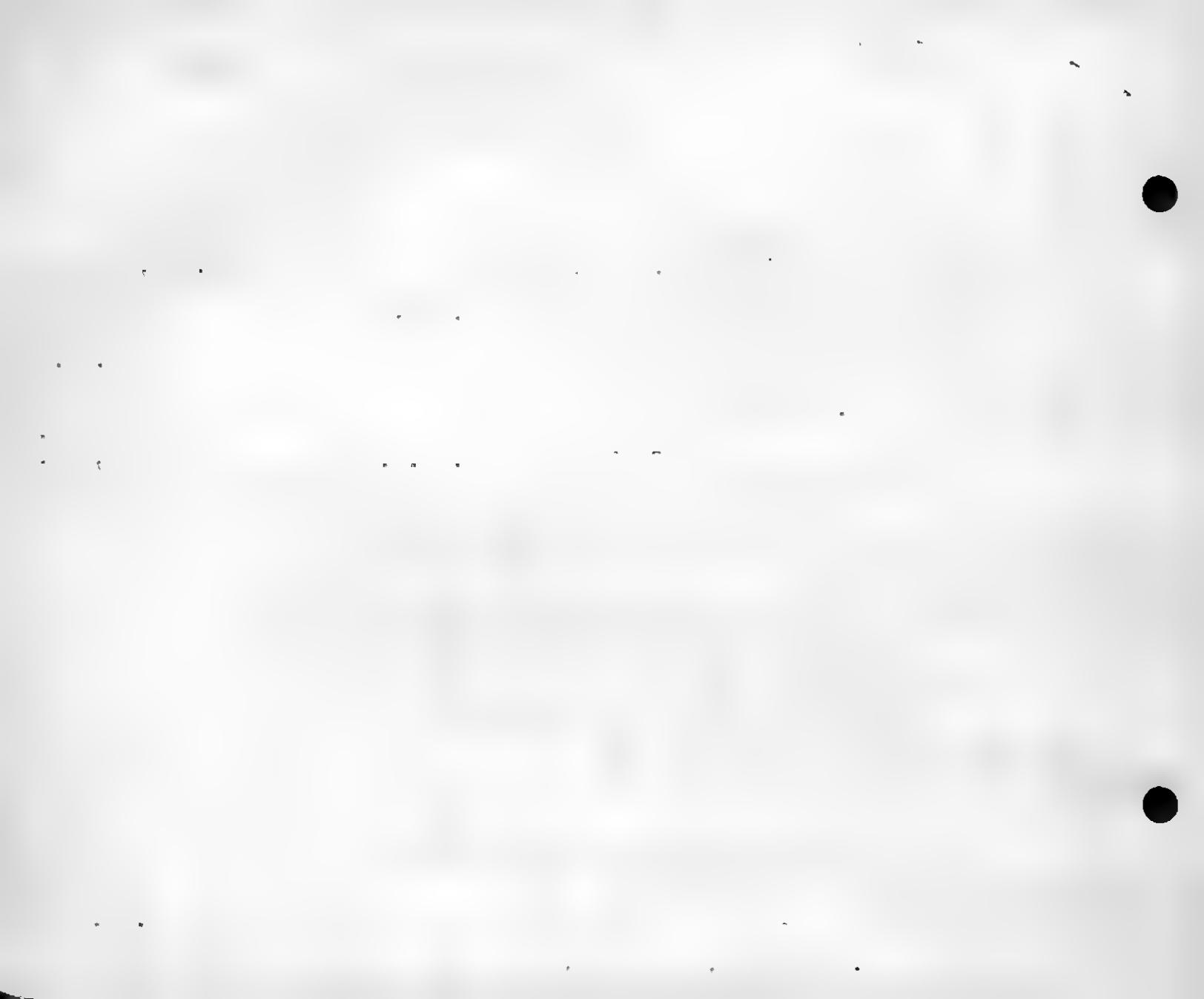
## CERTIFICATE OF DEATH

17361

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If you please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>XX Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN lb <b>4 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4600 Harlan Street</b>			d. STREET ADDRESS <b>4600 Harlan Street</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>CARRIE</b>	Middle <b>R.</b>	4. DATE OF DEATH <b>Dec. 21, 1966</b>	Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 11, 1877</b>	9. AGE (In years last birthday) yrs <b>89</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John F. Clarke</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ann Beall</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-07-4861D</b>		17. INFORMANT Daug. <b>Mrs. T.H. Dent</b> 7107 <sup>ss</sup> Georgia St. Chevy Chase, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>33IX</b> <i>Cerebral vascular accident</i> DUE TO (b) <i>Advanced cerebral arteriosclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>10 years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary infarct in left lung</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 15, 1935</b> , to <b>Dec 21, 1966</b> that (I) (we) last saw the deceased alive on <b>Dec 20, 1966</b> , and that death occurred at <b>9:32 A.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>D.B. Washington</b>			22b. DATE SIGNED <b>12/21/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>D. B. Washington MD</b>		22d. ADDRESS <b>580 1/2 Ridgefield Rd. Bethesda Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-22-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Creek Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JEG 27 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles George</b>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

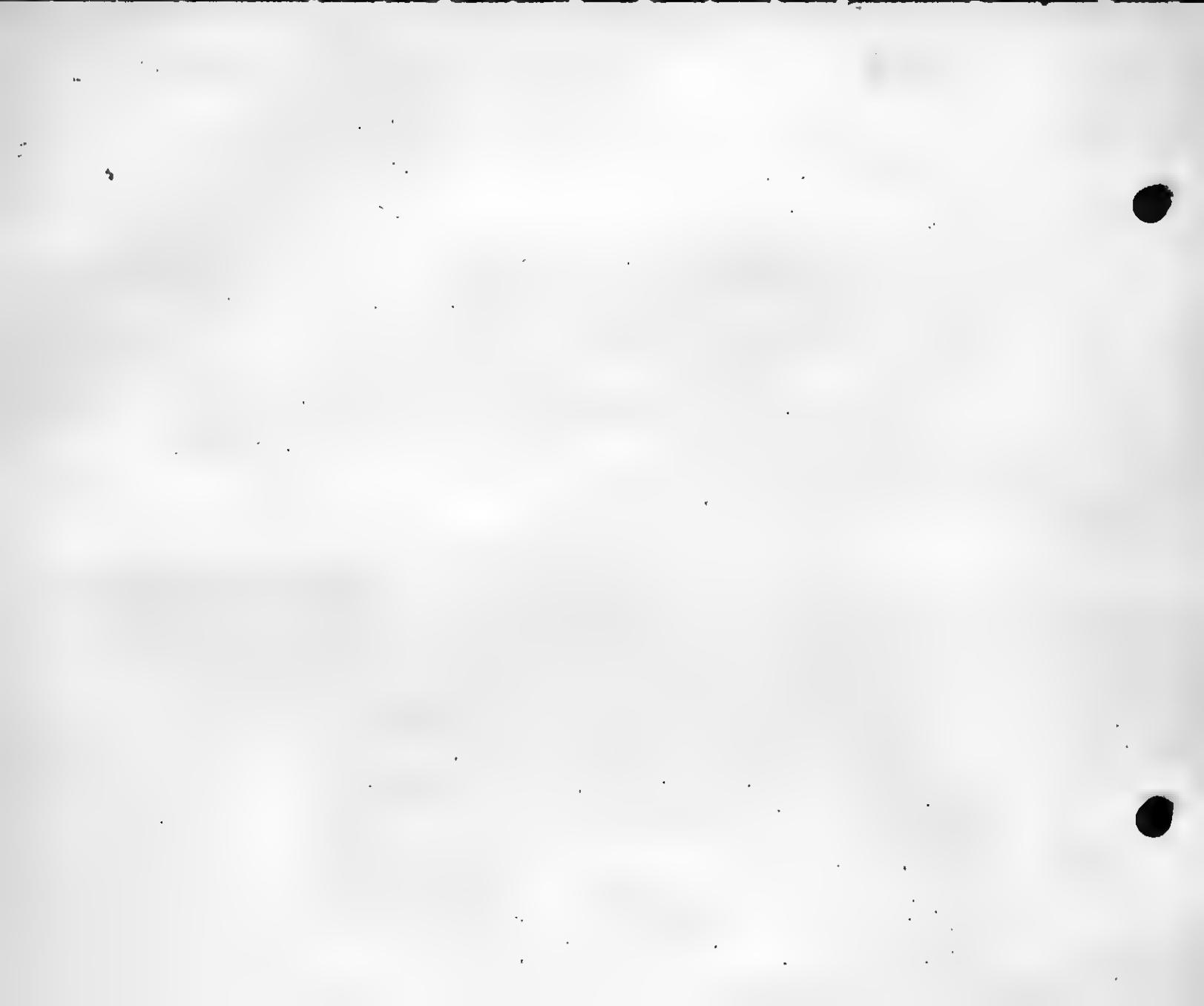
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17371

## CERTIFICATE OF DEATH

17362

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1D <i>1 year</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Cankhaven Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>CORA</i>	Middle <i>Emma</i>	Last <i>GRANINGER</i>
4. DATE OF DEATH Month <i>Dec</i>	Day <i>25</i>	Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 16, 1886</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S.G.V.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bureau Engr.</i>	
13. FATHER'S NAME <i>Thomas Polton</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
16. SOCIAL SECURITY NO. —		14. MOTHER'S MAIDEN NAME <i>Barbara Winters</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Parkinsonism</i>		Address <i>Henry Graninger #2</i>	
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) — (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>Undetermined</i>	
DUE TO			
DUE TO			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) —		(County) (State) —	
21. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , 19, to <i>Dec 25, 1966</i> , that (II) (we) last saw the deceased alive on <i>Dec 13, 1966</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Mullin J Simpson</i>		22b. DATE SIGNED <i>12/25/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>William F. Simpson</i>		ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <i>6216 N. Ft. Meade</i>			
23a. BURIAL/CREMATION METHOD (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 28, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>Greenwood</i>		23d. LOCATION (City, town or county) <i>Rockville</i>	
24. FUNERAL DIRECTOR <i>W.W. TAFT &amp; SULL</i>		ADDRESS <i>3603 Rockville Rd</i>	
25a. REC'D BY REGISTRAR DATE <i>JFC 2: 1966</i>		25b. REGISTRAR'S SIGNATURE <i>John F. Coughlin</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

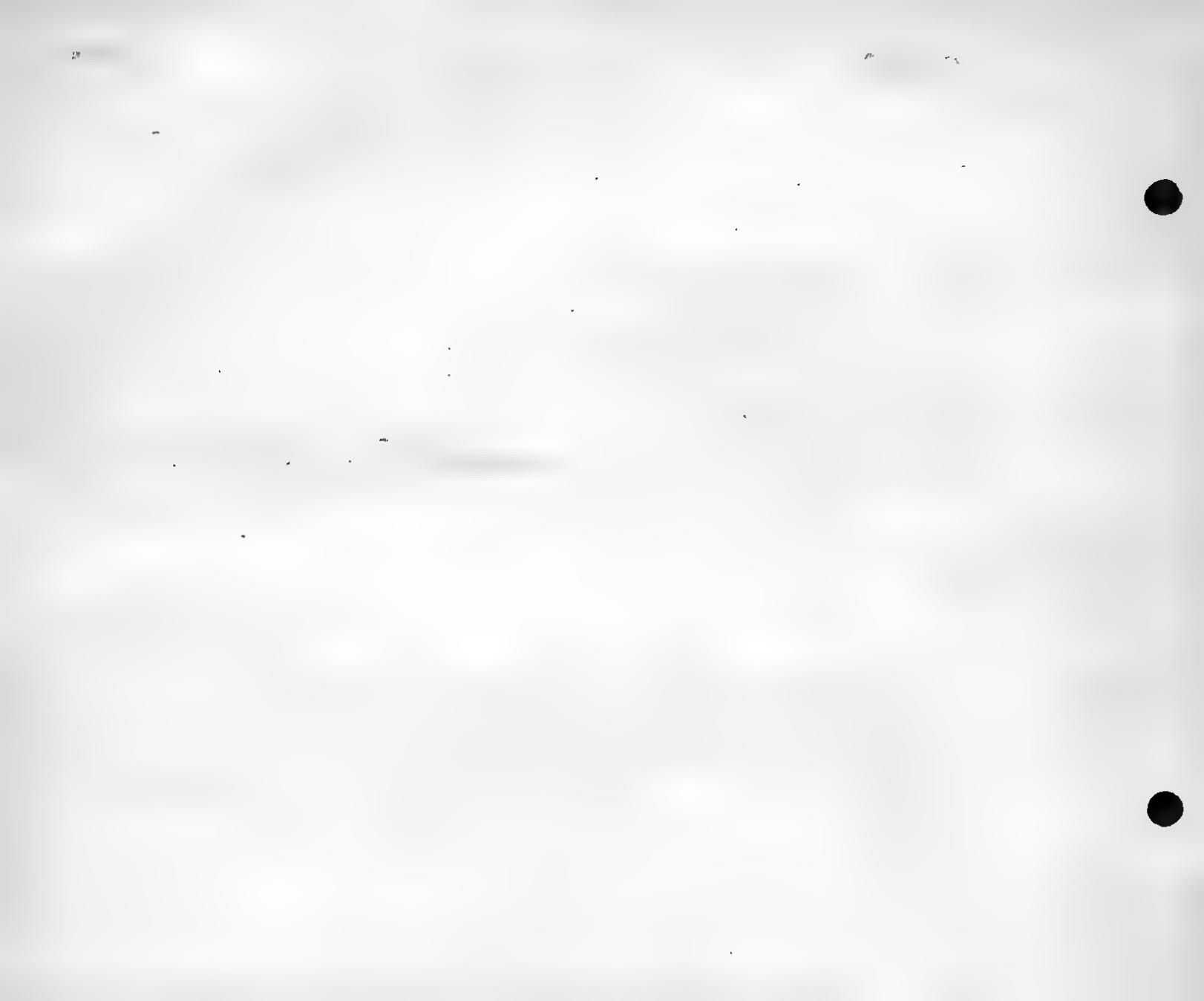
## CERTIFICATE OF DEATH

17368

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN TB <b>7 days / 12 hrs</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		e. STREET ADDRESS <b>8606 Flower Ave.</b>				
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>MARGARET LOUISE GRIMMINTZ</b>		4. DATE OF DEATH <b>DECEMBER 16 1966</b>	Month Day Year			
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 3, 1907</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <b>Hswf.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>				
11. BIRTHPLACE (Country & State, or foreign country) <b>Pax Johnstown, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Timothy Flinn</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN Waters</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If you give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO <b>yes Hospital records</b>				
17. INFORMANT <b>FREDERICK GRIMMINTZ</b>		Address <b>8319 33rd Ave., Mattawamkeag, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Mitral Stenosis Insufficiency</b> DUE TO (b) <b>Plaque Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 10, 1966</b> to <b>Dec 15, 1966</b> that (I) (we) last saw the deceased alive on <b>Dec 15, 1966</b> and that death occurred at <b>12 PM</b> , from causes and on the date stated above.						
22o. SIGNATURE <b>Boris Rabkin</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/17/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>BORIS RABKIN MD.</b>		22d. ADDRESS <b>1019 University Blvd. East</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 20, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>		
24. FUNERAL DIRECTOR <b>John B. Thomas</b>		ADDRESS <b>8434 Georgia Ave.</b>		25a. REC'D BY REGISTRAR <b>REC 27 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Mr. J. B. Thomas</b>	
20 M 1/66		25c. SIGNATURE <b>John B. Thomas</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17373

## CERTIFICATE OF DEATH

17364

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 16 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		e. STREET ADDRESS 1401 BLAIR MILL RD.	
3. NAME OF DECEASED (Type or print) BESSIE		First Middle Last GRUBER	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX F	6. COLOR OR RACE L	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 25 1891
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years last birthday) 76 YES
13. FATHER'S NAME LOUIS COLEMAN		11. BIRTHPLACE (County & State, or foreign country) RUSSIA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. — — —	17. INFORMANT JULIA KIRSON DAUGHTER
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9/22/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)		Address 1900 LYTONSHILL RD SILVER SPRING, MONTGOMERY	
		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) (a) Diabetes mellitus, (b) chronic Congestive Heart Failure, (c) Probable Bronchopneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 25, 1965</u> , to <u>December 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec. 5, 1966</u> , and that death occurred at <u>10.35 M</u> , from causes and on the date stated above.			
22a. SIGNATURE Gene U. Cohen, M.D.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED DEC. 5, 1966
22c. PHYSICIAN'S NAME (Type) GENE U. COHEN, M.D.		22d. ADDRESS 1106 SPRING ST SILVER SPRING, MARYLAND.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-7-66	23c. NAME OF CEMETERY OR CREMATORIAL GEORGE WASHINGTON CEMETERY
24. FUNERAL DIRECTOR Charles J. Judge Ch. Officier Funeral Home - 4217, 9th St		ADDRESS 4217, 9th St	25d. REC'D BY REGISTRAR DATE DEC 8 1966
			25b. REGISTRAR'S SIGNATURE Charles J. Judge

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FOR STATE  
HEALTH DEPT.

17374

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17365

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN lb <b>Wash San + Hospital</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wa Sh San + Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Edward Gude</b>		First	Middle
4. DATE OF DEATH <b>12-28-66</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <b>Never married</b>	8. DATE OF BIRTH <b>12-10-03</b>
9. AGE (In years last birthday) <b>63 yrs</b>	10. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>US</b>
10a. OCCUPATION (Give kind of work done during last 6 months of working life, even if retired) <b>farmer</b>	10b. FATHER'S NAME <b>John A. Gude</b>	14. MOTHER'S MAIDEN NAME <b>Ida Gleason</b>	15. ADDRESS <b>Mrs. Mabel Gude</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO <b>216 40 8172</b>	17. INFORMANT <b>Acute coronary insufficiency</b>	18. INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420/</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { stating the underlying cause lost. (b) DUE TO (c)		Coronary artery heart disease	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNA CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(City or town) (County) (State)</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden B. Keap M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) <b>Washington D. C.</b>	
22. DATE SIGNED <b>12/28/1966</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec 31, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Rock Creek Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	25a. RECEIVED BY REGISTRAR <b>JAN 3 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>J. Gasch's Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17375

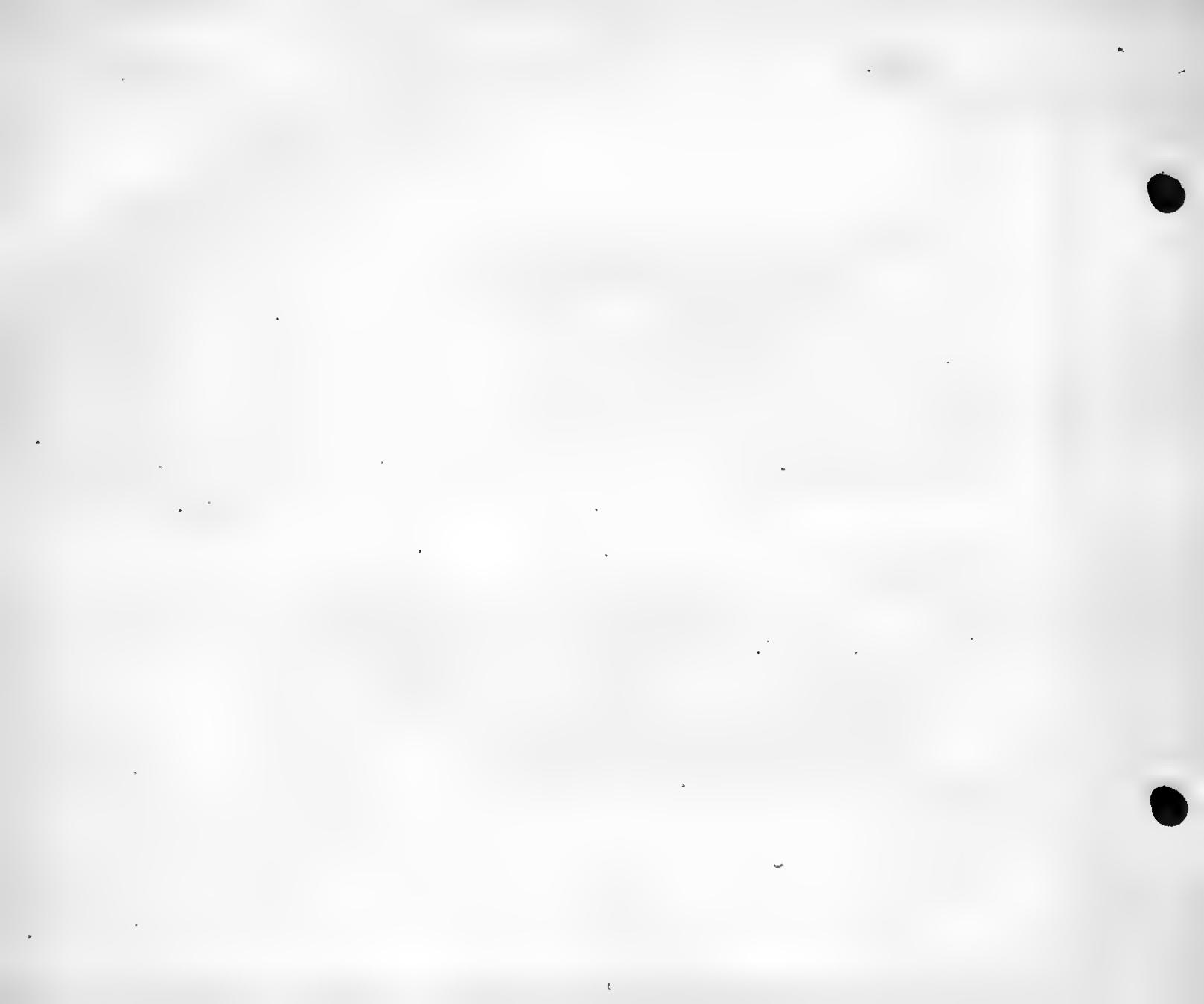
## CERTIFICATE OF DEATH

17366

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. PR. GEORG. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tysons Corner</u> d. STREET ADDRESS <u>1308 Merrimac Drive</u>		
d. LENGTH OF STAY IN TB <u>Suburbans</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) <u>John Cameron Hunter</u>		First	Middle	Lost	4. DATE OF DEATH Month <u>12</u> Doy <u>16</u> Year <u>1966</u>
S. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	B. DATE OF BIRTH <u>11/17/17</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Belmont T.D.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland Allegany Co. USA</u>	
13. FATHER'S NAME <u>George</u>		14. MOTHER'S MAIDEN NAME <u>Jane Cameron</u>		12. CITIZEN OF WHAT COUNTRY? <u>Address 8557 Bladensburg Rd. Greenbelt Md. 20770</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army</u>		16. SOCIAL SECURITY NO <u>217-01-7228</u>		17. INFORMANT <u>Mrs. Hunter</u>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage, gastro-intestinal, massive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { lost		DUE TO (b) <u>Esophageal varices</u> DUE TO (c) <u>Portal cirrhosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Year</u> <u>Year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pylonephritis, acute and chronic</u>				19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Arlington</u> (County) <u>Arlington</u> (State) <u>VA</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , to date <u>16</u> , 1966 that (I) (we) lost saw the deceased alive on <u>Dec 16</u> 1966, and that death occurred at <u>Apex</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Dewitt E. DeLauter</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>12/17/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dewitt E. DeLauter MD</u>		22d. ADDRESS <u>3848 Rockville St. NW Wash DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/20/66</u>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Arlington National Cemetery</u>	23d. LOCATION (City or Town) <u>Arlington</u> (County) <u>Arlington</u> (State) <u>VA</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
		1331 Rockville Pike Rockville, Maryland		DATE <u>DEC 22 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17376

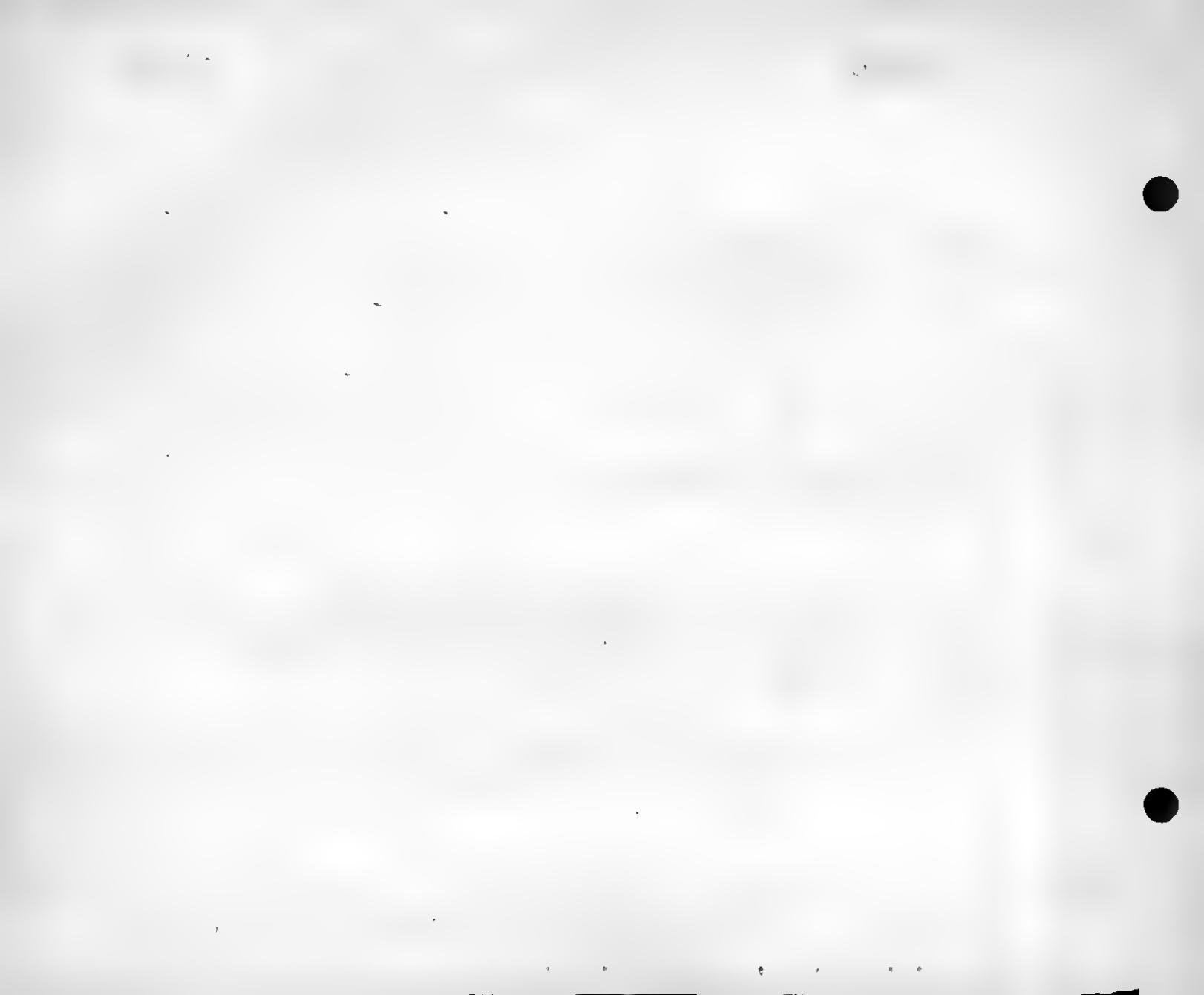
## CERTIFICATE OF DEATH

17367

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>		b. COUNTY <i>PRINCE GEORGES</i>	
c. LENGTH OF STAY IN lb <i>8 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BOWIE</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>12705 CHERRYWOOD LANE</i>	
3. NAME OF DECEASED (Type or print) <i>JAMES S. HAINES</i>		4. DATE OF DEATH <i>12 - 7 1966</i>	
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CHIEF STATISTICIAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DEPT. OF ARMY</i>	
13. FATHER'S NAME <i>JAMES Harry HAINES</i>		11. BIRTHPLACE (County & State, or foreign country) <i>WASH. D.C.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. SOCIAL SECURITY NO <i>578-24-5601</i>		17. INFORMANT Address <i>CARMA R. HAINES #2 above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral vascular thrombosis</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Bronchogenic carcinoma</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Blow to head</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>Dec 15 1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. (City or town) <i>Bethesda</i>		(County) (State) <i>Maryland</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 15, 1966</i> , to <i>Dec 7, 1966</i> , that (I) (we) last saw the deceased alive on <i>Dec 7, 1966</i> , and that death occurred at <i>2:04 P.M.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Ryan</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>Dec 7, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Jas. T. Ryan, Inc.</i>		22d. ADDRESS <i>841 COLESVILLE RD SILVER SPRING MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/10/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>
23d. LOCATION (City or Town) <i>Suitland</i>		(County) (State) <i>Maryland</i>	
24. FUNERAL DIRECTOR <i>Jas. T. Ryan, Inc.</i>		ADDRESS <i>317 Pa. Ave., SE DC3</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 12 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17377

CERTIFICATE OF DEATH

17368

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>11 days.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
3. NAME OF DECEASED (Type or print) <i>Tay</i>		4. DATE OF DEATH <i>7/11/66</i>	Month <i>July</i> Day <i>12</i> Year <i>1966</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/17/06</i>
9. AGE (In years from birthdate) <i>60 yrs</i>		9. AGE (In years from birthdate) <i>60 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i> Doy <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. LSLAI OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Civil engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Government</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D.C.</i>
13. FATHER'S NAME <i>J. W. Hall Jr.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO <i>578-32-5883</i>	17. INFORMANT Address <i>Mrs. LILLIAN C. HALL, 6929 04 Stage Rd. Rockville, MD</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction with rupture and tamponade</i> INTERVAL BETWEEN ONSET AND DEATH <i>14 days</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Coronary thrombosis</i> DUE TO (c) <i>Coronary arteriosclerosis</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>p.m.</i> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Rockville</i> (County) <i>MD</i> (State) <i>MD</i>
21. I certify that (I) (this hospital) attended the deceased from <i>February 9, 1966</i> , to <i>December 20, 1966</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>December 20, 1966</i> , and that death occurred at <i>9:30 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Joseph J. Connor</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED <i>8/12/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOSEPH J. CONNOR</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>12-23-1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Parklawn Cemetery</i>
24. FUNERAL DIRECTOR Joseph Hawley's Sons, Inc.		ADDRESS <i>5130 Wisc. Ave. D.C.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15 (4) 20 M 1/66			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17378

CERTIFICATE OF DEATH

17369

1. PLACE OF DEATH  
a. COUNTY

Montgomery MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

Bethesda

38 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

The Clinical Center, Bethesda, Md. 20014

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

b. COUNTY

Washington, D.C.

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Washington, D.C.

d. STREET ADDRESS

239 Oglethorpe Street, N.E.

e. IS RESIDENCE ON A FARM?

YES  NO

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year  
(Type or print) Tildia Margaret Hall December 7 1966

5. SEX 6. COLOR OR RACE 7. MARRIED  NEVER MARRIED  8. DATE OF BIRTH 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.  
Female Negro WIDOWED  DIVORCED  26 August 1928 38 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?  
Librarian US Government North Carolina USA

13. FATHER'S NAME Samuel Hall Catherine Jones Address  
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address  
(Yes, no, or unknown) (If yes give war or dates of service) The Medical Records

No Not Available The Clinical Center, Bethesda, Md. 20014

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN  
PART I. DEATH WAS CAUSED BY: ONSET AND DEATH  
IMMEDIATE CAUSE (a) Renal failure 2 days

204.1  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Blastic crisis 5 weeks

DUE TO  
(b) Blastic crisis 5 weeks

DUE TO  
(c) Chronic Myelogenous Leukemia 2 years

(c) Chronic Myelogenous Leukemia 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES  NO

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)  
Hour a.m. While at work  Not While at work   
p.m. 19

21. I certify that  (this hospital) attended the deceased from 30 October, 1966, to 7 December, 1966, that  (we) last saw the deceased alive on 7 December 1966, and that death occurred at 6:30M, from the causes and on the date stated above. PM

22b. DATE SIGNED

22a. SIGNATURE Paul P. Carbone MD

M.D. ATTENDING PHYS.  MED. DIRECTOR  STAFF PHYS.  8 December 1966

22c. PHYSICIAN'S NAME (Type) Paul P. Carbone

22d. ADDRESS The Clinical Center, National

Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL 23d. LOCATION (City, town or county) (State)  
19/12/66 Laurel

Suddard Md

24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  
John T. Russo - 3015-12-N.E. DATE DEC 15 1966 Charles Judy



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17379

## CERTIFICATE OF DEATH

17370

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Va. b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 230 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SYLVAN MANOR HEALTH Care Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First NELLIE	Middle V.	Last HAMILTON
4 DATE OF DEATH	Month 12	Day 14	Year 1966
5 SEX Female	6 COLOR OR RACE W	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH Apr. 24, 1893	9 AGE (In years last birthday) 73 yrs.	10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Bureau of Eng.
11 BIRTHPLACE (Country & State, or foreign country) Wash., D.C.	12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13 FATHER'S NAME Levi W Pennfield	14 MOTHER'S MAIDEN NAME Susie R. Grigsby		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO UNKNOWN	17 INFORMANT Joseph Cox, Son	Address Same as #2.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior sclerosis - General of DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1966 to _____, 19_____, that (I) (we) last saw the deceased alive on Nov. 9, 1966, and that death occurred at 11:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE Robert T. Thibadeau		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12-14-66
22c. PHYSICIAN'S NAME (Type) Robert T. Thibadeau		22d. ADDRESS 11,000 OLD GEORGIA RD. ROCKVILLE MD 20852	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/20/1966	23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VA
24. FUNERAL DIRECTOR W.W. Chambers Co - Washington, DC	ADDRESS	25a. REC'D BY REGISTRAR DATE DEC 19 1966	25b. REGISTRAR'S SIGNATURE Charles Judd



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

17380

## CERTIFICATE OF DEATH

17371

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial; cremation, or removal, and/or any event, within 72 hours after death.

<b>PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN lb <b>18 yrs</b>			<b>2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)</b> d. STATE <b>MD</b> e. COUNTY <b>MONTGOMERY</b> f. CITY OR TOWN (If outside corporate lim.ls, write RURAL and give nearest town) <b>SILVER SPRING</b> g. STREET ADDRESS <b>529 DALE DRIVE</b> h. IS RESIDENCE ON A FARM? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>				
<b>3. NAME OF DECEASED</b> First <b>CARROLL</b> , Middle <b>Caswell</b> , Last <b>HARDING</b> (Type or print)			<b>4. DATE OF DEATH</b> Month <b>12</b> Day <b>28</b> Year <b>1966</b>				
<b>5. SEX</b> <b>M</b>		<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8-3-95</b> <b>9. AGE (In years last birthday)</b> <b>71 yrs</b>			
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Retired Physician</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Juda</b> <b>Retweiller</b>		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <b>MD</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>ZACHARIAH</b> Harding			<b>14. MOTHER'S MAIDEN NAME</b> <b>GRACE Hodson</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> <b>Yes</b> <b>(If no, or unknown)</b> <b>(If yes give war or dates of service)</b> <b>WWII Army</b>		<b>16. SOCIAL SECURITY NO.</b> <b>549-32-1819</b>		<b>17. INFORMANT</b> <b>Marie U. Harding</b> , Address <b>529 Dale Drive, Silver Spring, Md.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Shack - Septic</b> <b>DUE TO</b> <b>(b)</b> <b>Anorectitis -</b> <b>DUE TO</b> <b>(c)</b> <b>Q-tetraoselvate Heart Disease</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>12 hours</b> <b>unknown</b> <b>years -</b>				
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>						<b>19. WAS AUTOPSY PERFORMED?</b> <b>NO <input checked="" type="checkbox"/></b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> <input type="checkbox"/> <b>(If either, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20d. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from <b>Dec 25, 1966</b> to <b>Dec 28, 1966</b>, that (I) (we) last saw the deceased alive on <b>Dec 28, 1966</b>, and that death occurred at <b>649 PM</b>, from causes and on the date stated above.</b>						<b>22b. DATE SIGNED</b> <b>Dec 28, 1966</b>	
<b>22a. SIGNATURE</b> <b>Lysle Williams</b>		<b>M.D.</b> <input checked="" type="checkbox"/> <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <b>831 University Blvd E Silver Spring</b>		<b>22b. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS</b> <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Dec 31, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORIAL</b> <b>Forest Oak Cemetery</b>		<b>23d. LOCATION (City or Town)</b> <b>(County)</b> <b>(State)</b> <b>Gaithersburg, Maryland</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Warner E. Pumphrey, Inc.</b>		<b>8434 ADDRESS</b> <b>Georgia Avenue</b>		<b>25a. RECD BY REGISTRAR</b> <b>JAN 3 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles J. Jr.</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17381

CERTIFICATE OF DEATH

17372

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Penna. b. COUNTY Dauphin ✓						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb 9 years	c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Harrisburg		d. STREET ADDRESS Chestnut Street				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Nursing Home			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3 NAME OF DECEASED First LILLIE Middle C. Last HARRIS		4. DATE OF DEATH Month DECEMBER Day 4 Year 1966							
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1873	9. AGE (In years last birthday) 93 yrs	10. IF UNDER 1 YEAR Months Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Nicholas I. Hench			14. MOTHER'S MAIDEN NAME Ann Ellen Weakley						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Nursing Home Records		Address Same as Item 1.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis						INTERVAL BETWEEN ONSET AND DEATH CONFINED			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Essential Hypertension									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Essential Hypertension									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Essential Hypertension									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Essential Hypertension									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12-3, 1957, to 12-4, 1966, that (I) (we) last saw the deceased alive on DEC. 4, 1966, and that death occurred at 9:30 A.M. from causes and on the date stated above.									
22a. SIGNATURE Henry M. Lowden			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/4/66		
22c. PHYSICIAN'S NAME (Type) Henry M. Lowden			22d. ADDRESS 5206 Norway Dr Chevy Chase, Md.						
23a. BURIAL CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 12-4-66		23c. NAME OF CEMETERY OR CREMATORIAL Harrisburg Cemetery		23d. LOCATION (City or Town) (County) (State) Harrisburg, Penna.			
24. FUNERAL DIRECTOR Robert A. Humphrey			ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE DEC 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



Items 18&21 Film 507 4-20 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE  
HEALTH DEPT.

17382

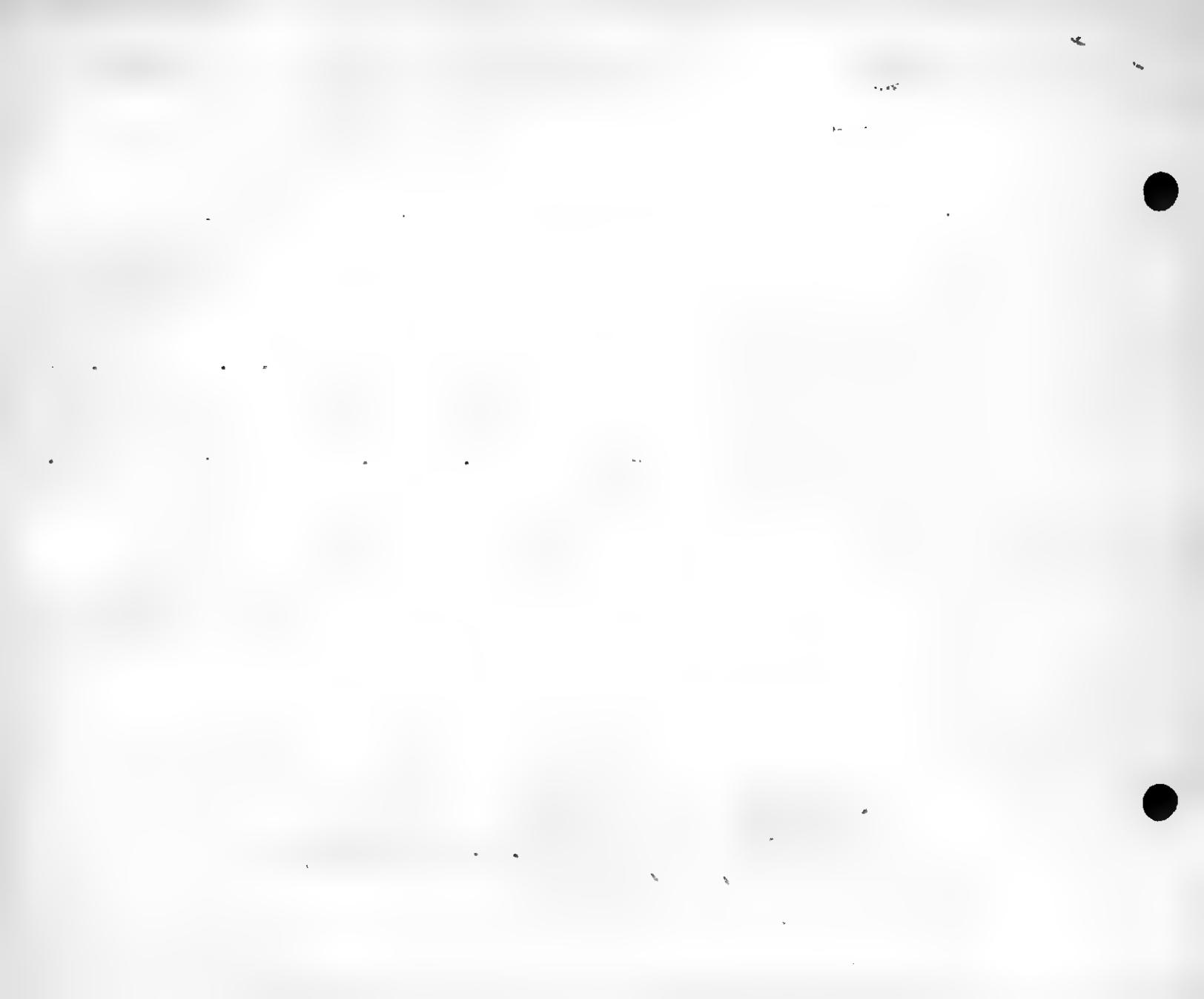
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17373

To MARYLAND ATTORNEY: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a COUNTY <i>Montgomery</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b STATE <i>Maryland - Montgomery</i>	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c LENGTH OF STAY IN lb <i>1701 East West Hwy.</i>		b COUNTY c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>1701 East West Hwy.</i>		d STREET ADDRESS <i>1701 East West Hwy.</i>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>John William Hartig</i>		First	Middle	LAST	4. DATE OF DEATH Month Day Year <i>12-21 1966</i>
5 SEX <i>Male</i>		6 COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 5, 1894</i>
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hardware - Retired</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11 BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>	
13 FATHER'S NAME <i>Gustave Hartig</i>		14 MOTHER'S MAIDEN NAME <i>Katherine Weber</i>		12 CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>WW I</i>		16 SOCIAL SECURITY NO <i>578-03-6197</i>		17 INFORMANT Sister <i>4814 Chevy Chase Blvd</i> Mrs. Ida H. Ray <i>Chevy Chase, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4200 Congestive heart failure</i>		DUE TO <i>Arteriosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerotic heart disease</i>		DUE TO <i>(b)</i>			
DUE TO <i>(c)</i>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19 WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)			
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d INJURY OCCURRED While Not While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>(City or town) (County) (State)</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, City, Town, or County) <i>Belden R. Read, M.D.</i>	
ACTUAL SIGNATURE <i>Belden R. Read</i>		EXAMINER'S NAME (Type) <i>BELDEN R. READ, M.D.</i>		22. DATE SIGNED <i>12/21/1966</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>12-27-66</i>		23c NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>	
23d LOCAT ON (City or Town) <i>Suitland, Maryland</i>				(County) (State)	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. RECEIVED BY REGISTRAR DATE <i>DEC 27 1966</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17383

## CERTIFICATE OF DEATH

17374

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland		b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 38 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 761 Silver Spring Avenue							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 761 Silver Spring Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Lora		First	Middle	Last	4. DATE OF DEATH Harvey	Month	Day	Year					
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1884	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Henry Baker		14. MOTHER'S MAIDEN NAME Unknown											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT William H. Summers 716 Silver Spring Ave. Silver Spring, Md.		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Nephrosclerosis Arterosclerosis													
INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs. 5 yrs.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19							20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hyattsville	(County) Maryland	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from Aug. 1961 to December 1966 that (I) (we) last saw the deceased alive on December 21, 1966, and that death occurred at 10:57 P.M. from the causes and on the date stated above.									22a. SIGNATURE Glen Carter	22b. DATE SIGNED 12/21/66			
22c. PHYSICIAN'S NAME (Type) RALPH F. PATTERSON 1407 modesto Rd.									M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	23d. LOCATION (City, town, or county) Hyattsville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 24, 1966		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem.		23d. LOCATION (City, town, or county) Hyattsville, Maryland							
24. FUNERAL DIRECTOR G. Glen Carter Warner E. Purphrey, Inc.		ADDRESS C. Glen Carter 18434 Georgia Ave.		25a. REC'D BY REGISTRAR 1966		25b. REGISTRAR'S SIGNATURE							
				DATE									



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17384

CERTIFICATE OF DEATH

17375

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Betty</b>	Middle <b>Jean</b>	4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1966</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>22 June 1958</b>
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John T. Hawkins</b>		14. MOTHER'S MAIDEN NAME <b>Nora Bourne</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>Pulmonary insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
IMMEDIATE CAUSE (a) <b>289.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cystic fibrosis of pancreas</b>		DUE TO <b>8 years</b>	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>Dec. 13, 1966</b> , to <b>Dec. 26, 1966</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>Dec. 26, 1966</b> , and that death occurred at <b>10:37M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Georges Peter</b>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>27 December 1966</b>
22c. PHYSICIAN'S NAME (Type) <b>Georges Peter, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>12/27/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Virginia Beach, Va.</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>		24d. ADDRESS <b>Bethesda, Md.</b>	25a. REC'D BY REGISTRAR <b>DEC 30 1966</b>
			25b. REGISTRAR'S SIGNATURE <b>a ge</b>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17385

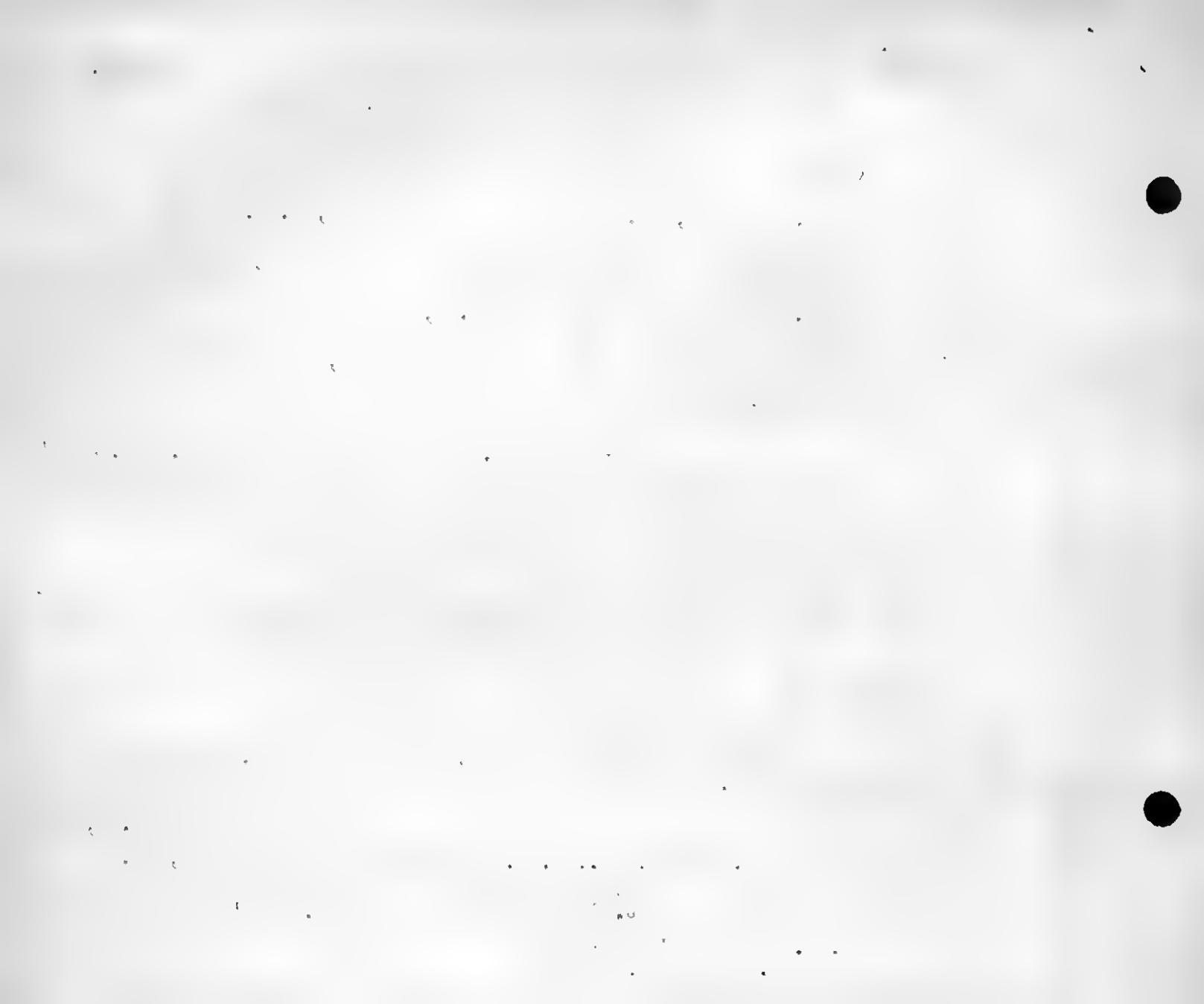
CERTIFICATE OF DEATH

17376

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) b. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN b. 59 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital, Bethesda, Md.		e. STREET ADDRESS 301 G Street, S. W.	
3. NAME OF DECEASED First Olive Middle Barbara HAYES		4 DATE OF DEATH December 1 Year 1966	
3. NAME OF DECEASED (Type or print)		5. SEX	
Female Cauc.		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X		8. DATE OF BIRTH Jan. 2, 1929	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) 37 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nutritionist		10b. KIND OF BUSINESS OR INDUSTRY Public Health	
11. BIRTHPLACE (County & State, or foreign country) Bay Roberts, Newfoundland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Archibald Hayes		14. MOTHER'S MAIDEN NAME Zelah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Yes -PHS		16. SOCIAL SECURITY NO. 025-26-8866	
17. INFORMANT Newfoundland Address Mrs. Zelah Hayes, 11 Gower St., St. John's			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		7. INTERVAL BETWEEN ONSET AND DEATH months Adenocarcinoma of colon, metastatic	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 3, 1966, to Dec. 1, 1966, that (I) (we) last saw the deceased alive on Dec. 1, 1966, and that death occurred at 815AM, from causes and on the date stated above.		22b. DATE SIGNED Dec. 1, 1966	
22c. PHYSICIAN'S SIGNATURE Francis D. Keenan, Jr., M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify Burial) 12-5-66		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Pleasant Cemetery	
24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home ADDRESS 7557 Wisconsin Ave., Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE DEC 5 1966	
		25b. REGISTRAR'S SIGNATURE	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G-64 12/30/66 mh

17386

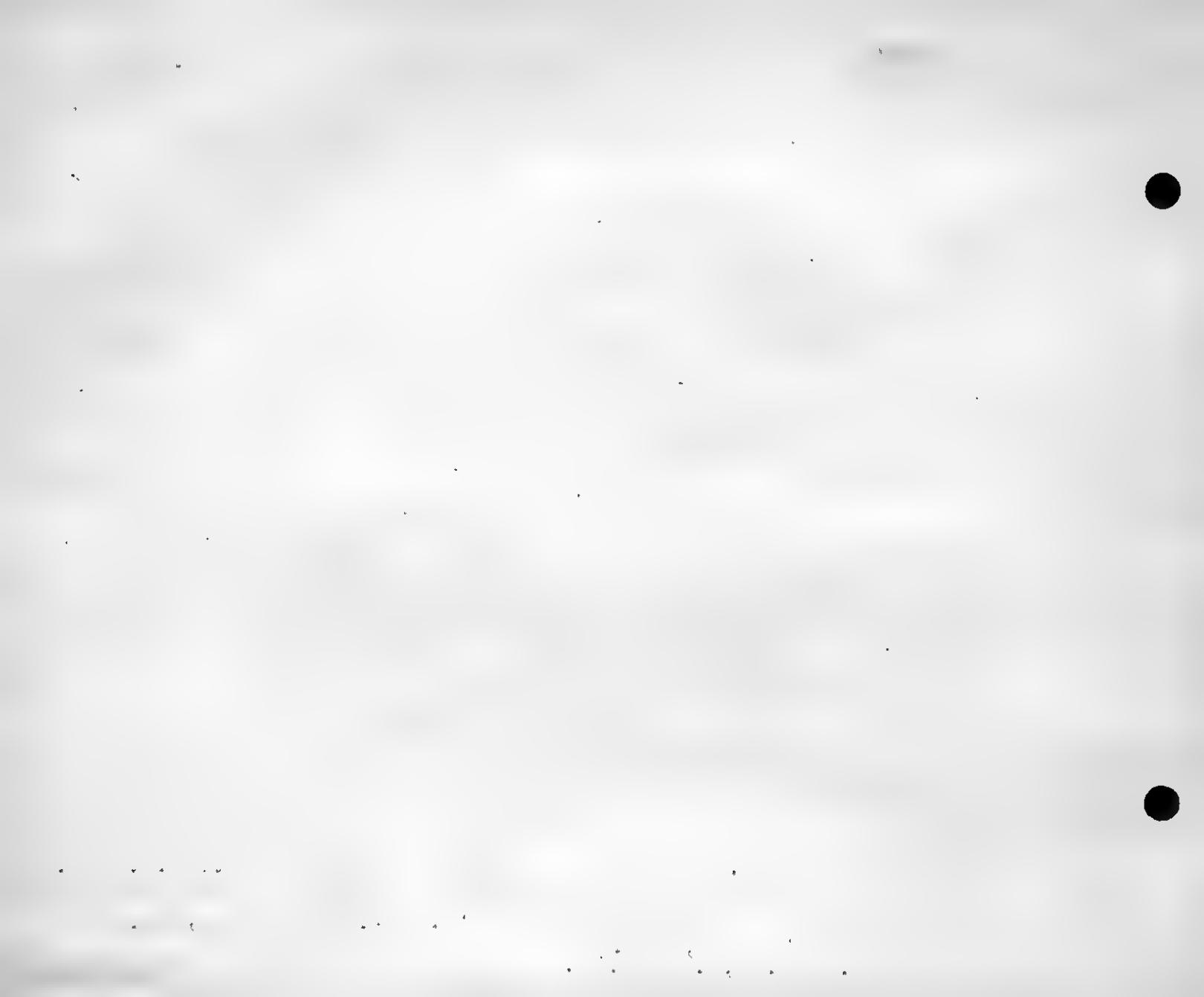
17377

## CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Md.</i> Geo. <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> Hyattsville		c. LENGTH OF STAY IN 1b <i>Hyattsville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kensington Gardens</i>		d. STREET ADDRESS <i>4200 Hamilton St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First <i>Elizab</i> Middle <i>C</i> Surname <i>Henricks</i>		4. DATE OF DEATH Dec. 9 1966	
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT. 11, 1878</i> 9. AGE (in years last birthday) <i>88 yrs</i>
10a. U.S. JAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Alexander R Clayton</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Mc Ceney</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>- - -</i>	
17. INFORMANT <i>H.W. Clayton. 1918-Metzgerott Rd.</i>		Address <i>Adelphi, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>general debility</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>generalized arteriosclerosis</i> (b) <i>15 yrs</i> DUE TO (c) <i>herpes zoster</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>herpes zoster</i>		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>-</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>3-5</i> (County) <i>Arlington</i> (State) <i>Va.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>3-5</i> , 19 <i>64</i> , to <i>12-9</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>12-7 1966</i> , and that death occurred at <i>4:05 PM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>12-9-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>D. P. Sengstack M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>9241 COLUMBIA BLVD., S.S., MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-14-1966</i> 23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Nat'l. Cem.</i> 23d. LOCATION (City or Town) <i>Arlington</i> (County) <i>Va.</i> (State)	
24. FUNERAL DIRECTOR <i>Joseph Lawler's Sons, Inc.</i> ADDRESS <i>5130 Wisconsin Ave. N.W. Wash. DC.</i>		25a. REG'D BY REGISTRAR <i>DEC 19 1966</i> DATE <i>12-19-66</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17387

## CERTIFICATE OF DEATH

17378

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TACOMA PARK</b>	LENGTH OF STAY IN 1b <b>19hrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TACOMA PARK.</b>	b. COUNTY <b>MONT.</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGON SAN &amp; Hospt.</b>		d. STREET ADDRESS <b>7817, Flower Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>THOMAS</b>	Last <b>HEPBURN</b>
4. DATE OF DEATH Month <b>12</b>	Month <b>17</b>	Day <b>19</b>	Year <b>66</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <b>3-04-05</b>		9. AGE (in years last birthday) <b>61 yrs.</b>	10. IF UNDER 1 YEAR Months Days
10. IF UNDER 24 HRS Hours Min		11. BIRTHPLACE (County & State, or foreign country) <b>D C</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Foreman</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>---</b>	
17. INFORMANT <b>P.T.S RECORD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatal artery thrombosis</b> . DUE TO <b>1621</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Obstruction in coronary arteries due to thickening of coronary left large vessels</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>			
DUE TO <b>(b) Coronary insufficiency due to thickening of coronary left large vessels</b>			
DUE TO <b>(c) Paroxysmal palpitation (Bronchospasm)</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Exacerbation of bronchitis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>
20f. (City or town) <b>---</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1966</b> , to <b>Dec 17, 1966</b> , that (I) (we) last saw the deceased alive on <b>12/17/66</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>N.C. SHOEMAKER M.D.</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12-17-66</b>
22c. PHYSICIAN'S NAME (Type) <b>N.C. SHOEMAKER M.D.</b>		22d. ADDRESS <b>811 Dale Dr. Silver Spring MD 20910</b>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Funeral</b>	23b. DATE THEREOF <b>Dec 20, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Memorial Garden</b>	23d. LOCATION (City or Town) <b>Silver Spring</b> (County) (State) <b>Md</b>
24. FUNERAL DIRECTOR <b>Hutchinson Funeral Home Owings, Md.</b>	ADDRESS <b>1111 Park Rd</b>	25a. REC'D BY REGISTRAR <b>REC'D</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Morris Judge</b>
DATE <b>DEC 21 1966</b>		DATE <b>DEC 21 1966</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE  
HEALTH DEPT.

17388

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17379

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

## PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp to give street address)

Wash San + Hospital

3. NAME OF  
DECEASED  
(Type or print)First  
Middle

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. STREET ADDRESS

804 Colby Ave.

e. IS RESIDENCE  
ON A FARM?  
YES  NO 

3. SEX

6. COLOR OR RACE

7. MARRIED

8. DATE OF BIRTH

9. AGE (In years  
lost birthday)10. MONTH  
YEAR

Female Negro

WIDOWED

NEVER MARRIED

1889

12  
1966

DIVORCED

2/25/011

60/77 yrs

10. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

none

12. CITIZEN OF WHAT  
COUNTRY? U.S

14. MOTHER'S MAIDEN NAME

Joseph Ross

Mary Jane Birch

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, No, or Unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT  
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Acute coronary insufficiency;

INTERVAL BETWEEN  
ONSET AND DEATH

+20/1

DUE TO

Conditions, if any, which gave  
rise to immediate cause (a),  
stating the underlying cause

Arteriosclerotic heart disease

(b)

DUE TO

(c)

DUE TO

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

20. MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS

PRIMARY  or CONTRIBUTING 

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day Year

20d. INJURY OCCURRED

Hour o.m.

While  Not While 

p.m.

at work  or work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

20g. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion

death resulted from:

Natural causes Accident Suicide Homicide Undetermined manner ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

22. DATE SIGNED

Belden R. Reed

M.D.

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Auditor (Street, City, Town, or County)

12/22/1966

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

DATE 12/22/1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



Items 10-21 Film 306 3-25 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17389

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17389

*D. R. Peap*  
delay is  
If  delay is  
10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If  delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit file page. Hand 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>D. of C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Sara</b>		4. DATE OF DEATH Month Day Year <b>December 30, 1966</b>	
S. SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED	8 DATE OF BIRTH <b>Jan. 30, 1899</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>Felipe Rosas</b>		14. MOTHER'S MAIDEN NAME <b>Jauna Gonsales</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No or Unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address <b>7600 Carroll Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute subdural and cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>due to fall at home</b>			
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Deceased fell at home and hit head</b>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>7:00 AM</b> p.m. <b>12/29 1966</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
		20f (City or town) <b>Washington</b>	(County) <b>D.C.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Peap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. PEAP M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22. DATE SIGNED <b>12/30/1966</b>	
23b DATE THEREOF <b>1/3/67</b>		23c NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cem.</b>	
23d LOCATION (City or Town) <b>Montgomery County, Md.</b>		(County) <b>Montgomery County</b>	
24 FUNERAL DIRECTOR <b>The S. H. Hines</b>		(State) <b>Md.</b>	
ADDRESS <b>1001 15th St. N.W. Washington, D. C.</b>		25a. RECEIVED BY REGISTRAR <b>JAN 3 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. If Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH					17381						
17390											
1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN TB <b>years.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> 151						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6702 Hillcrest Place</b>		d. STREET ADDRESS <b>6702 Hillcrest Place</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3 NAME OF DECEASED (Type or print) <b>Adelene Moore</b>		First	Middle	Last	4 DATE OF DEATH <b>Dec 21</b>	Month	Day	Year			
S. SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan 24, 1900</b>	9 AGE (In years last birthday) <b>66 YES</b>	IF UNDER 1 YEAR Months	F UNDER 24 HRS Days	Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>William W. Moore</b>		14. MOTHER'S MAIDEN NAME <b>Georgiana Johnson</b>			Address						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>578-50-6060</b>			17. INFORMANT <b>Virginia Herwig</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Rheumatic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>		
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. <b>Arteriosclerosis</b>		DUE TO (b) DUE TO (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <b>Arteriosclerosis</b>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B) <b>Wh e at work</b>			20d. INJURY OCCURRED Wh e at work <input type="checkbox"/> Nat Wh e at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg, etc.)		20f. (City or Town) <b>Arlington</b>	(County) <b>Arlington</b>	(State) <b>Virginia</b>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>											
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									22. DATE SIGNED <b>12/22/66</b>		
ACTUAL SIGNATURE <b>John G. Ball</b>									CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type)									Address (Street, city, town, or county) <b>Arlington, Virginia</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-27-66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington Natl. Cem.</b>		23d. LOCATION (City or Town) <b>Arlington, Virginia</b>		(County) (State)			
24. FUNERAL DIRECTOR <b>Rinaldi Funeral Home</b>		ADDRESS <b>7400 Georgia Ave, NW Washington, D.C.</b>		REC'D. BY REGISTRAR <b>DEC 27 1966</b>		DATE		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17391

## CERTIFICATE OF DEATH

Reg. Dist. No.

17382

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montg.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY Montg.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL <i>Foolesville</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL <i>Foolesville</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) <i>Jelen William Hickman</i>		First	Middle	Last	4 DATE OF DEATH Month 12 Day 19 Year 1966	Month	Day	Year		
S SEX <i>m</i>	COLOR OR RACE <i>w</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Sept 12-1887</i>	9 AGE (In years last birthday) yrs 79	IF UNDER 1 YEAR IF UNDER 24 HRS					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Hazel Hickman</i>		14. MOTHER'S MAIDEN NAME <i>Melissa Mc Gahen</i>		INFORMANT <i>Mrs Carolyn Hickman Foolesville Md</i>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16. SOCIAL SECURITY NO <i>218-30-2609</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 weeks</i>						
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>Hypostatic pneumonia</i>		Hypotension						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <i>Hypotension</i>		Cerebrovascular disease years						
DUE TO (c)										
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hepatosplenomegaly</i>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) <i>Blunt force trauma</i>		20c. TIME OF INJURY Month Day Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Sept 18</i> , 1966, to <i>Dec 19</i> , 1966, that I last saw the deceased alive on <i>18 Dec 1966</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>ADDRESS</i>		DATE SIGNED <i>12/19/66</i>								
ACTUAL SIGNATURE <i>John J. Fawcett M.D.</i>		PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>12/21/66</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Monocacy</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Constance C. Hilton Barnesville Md</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>DEC 23 1966</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

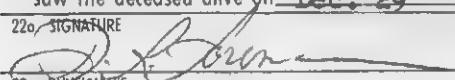
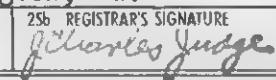
17392

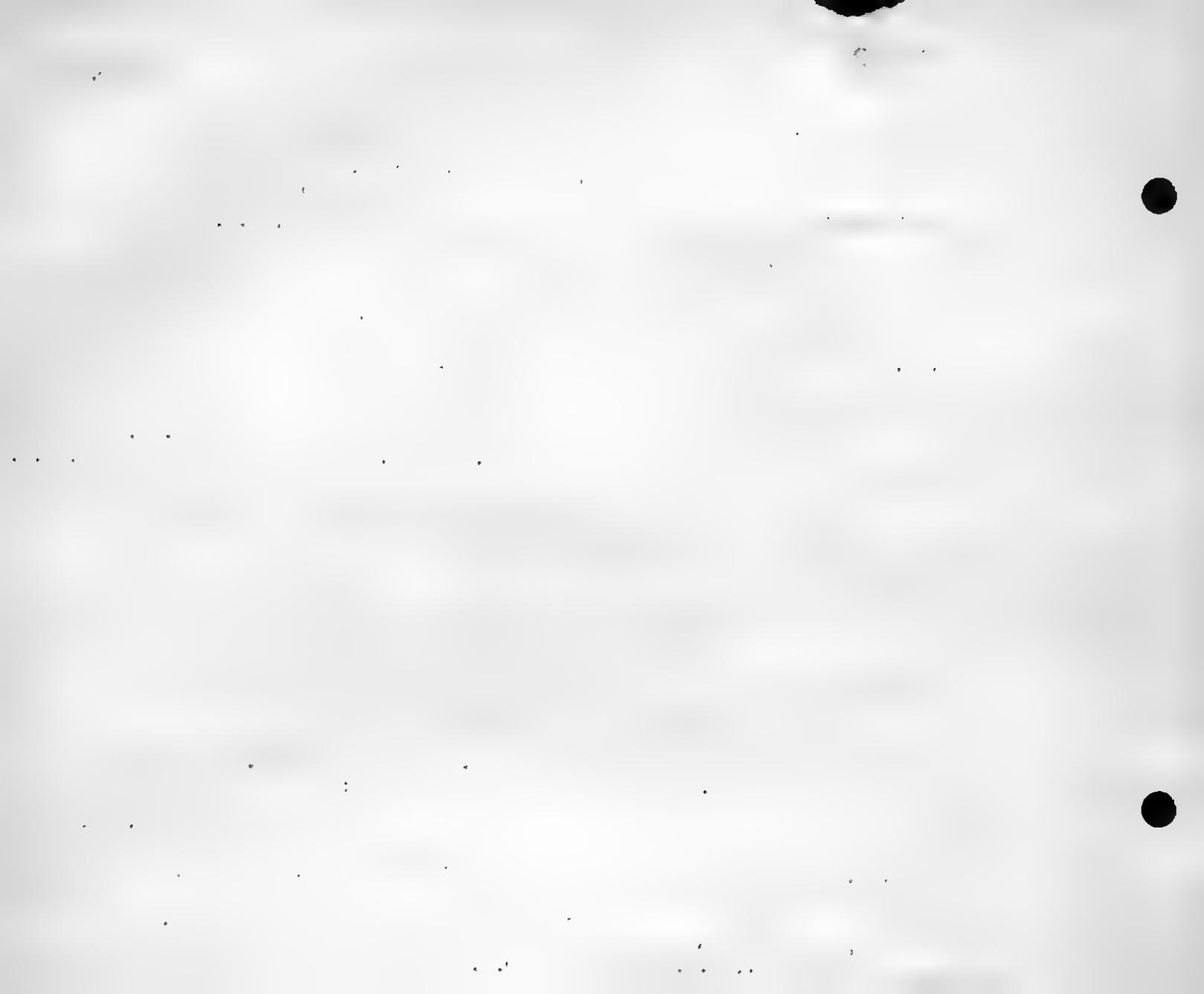
## CERTIFICATE OF DEATH

17383

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH D. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) D. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda,</b>		c. LENGTH OF STAY IN lb <b>14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>Officer's Service Club 1644 21st Street, N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Landon</b>		First <b>Landon</b>	Middle <b>Prescott</b>	Last <b>HILL</b>	4. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>1966</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/>	B. DATE OF BIRTH <b>February 14, 1919</b>	9. AGE (In years last birthday) <b>47 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Air Force</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Mena, Arkansas</b>	
13. FATHER'S NAME <b>Charles Franklin Hill</b>		14. MOTHER'S MAIDEN NAME <b>Martha</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1941-1963</b>		16. SOCIAL SECURITY NO <b>068 18 6863</b>		17. INFORMANT <b>Washington</b> Address D. C. <b>Mrs. Zita M. Hill (wife)</b> 3051 31st St., N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Due to <b>Massive gastrointestinal hemorrhage secondary to ruptured esophageal varices</b>				INTERVAL BETWEEN ONSET AND DEATH	
(b) Due to <b>Laennec's cirrhosis</b>					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <b>(s)</b> (this hospital) attended the deceased from <b>Dec. 15</b> , 19 <b>66</b> to <b>Dec. 29</b> , 19 <b>66</b> , that <b>(s)</b> (we) last saw the deceased alive on <b>Dec. 29</b> , 19 <b>66</b> , and that death occurred at <b>4:00AM</b> , from causes and on the date stated above.					
22a. SIGNATURE 				22b. DATE SIGNED <b>Dec. 30, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. R. FOREMAN, LT, MC, USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/3/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons</b> 5130 Wisconsin Ave., N.W. Washington, D.C.		ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 9 1967</b>	25b. REGISTRAR'S SIGNATURE 



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17393

## CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <i>MONTGOMERY</i>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <i>New Hampshire</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>KENSINGTON</i>		c LENGTH OF STAY IN 1b <i>5 yrs</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>KENSINGTON GARDENS SANATORIUM</i>		e STREET ADDRESS <i>ALSTEAD CENTER</i>	
3 NAME OF DECEASED (Type or print) <i>Sylvia</i>		First <i>Delano</i>	Middle <i>Hitch</i>
4 DATE OF DEATH <i>Dec 26 1966</i>	Month <i>Dec</i>	Day <i>26</i>	Year <i>1966</i>
5 SEX <i>F</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH <i>April 18 1867</i>
9 AGE (In years last birthday) <i>99 yrs</i>	10 IF UNDER 1 YEAR Months <i>0</i>	11 IF UNDER 24 HRS Days <i>0</i>	12 IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State or foreign country) <i>New York</i>	
13. FATHER'S NAME <i>Henry Foster Hitch</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Delano</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>NO</i>		16. SOCIAL SECURITY NO <i>216-46-0915</i>	17. INFORMANT <i>GARRAT B VAN WAGENEN DEGEN COL.</i>
Address <i>1050 CORONA ST</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY <i>450.0</i> IMMEDIATE CAUSE (a) <i>External causes, closing of senility</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>5 yr + 7</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fracture both hips prior to Dec 1961</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b.) <i>While at work</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>3721 Main Ave. N.W. Wash. DC</i>
20f. (City or town) <i>DC</i>		(County) <i>D.C.</i> (State) <i>DC</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 26 1966</i> , to <i>Dec 26 1966</i> that (I) (we) last saw the deceased alive on <i>Dec 4 1966</i> , and that death occurred at <i>6 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>R. Blasie Page</i>			
22c. PHYSICIAN'S NAME (Type) <i>R. Blasie Page</i>		22d. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>Dec 26 1966</i>
23a. BURIAL, CREMATION, Cremation Specified <i>CREMATION</i>		23b. DATE THEREOF <i>12/27/66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>CEDAR HILL CEMETERY</i>
23d. LOCATION (City or Town) <i>PRINCE GEORGES, MARYLAND</i>		(County) <i>PRINCE GEORGES</i> (State) <i>MARYLAND</i>	
24. FUNERAL DIRECTOR WILHELM FUNERAL HOME ADDRESS <i>4308 SUITLAND ROAD, SUITLAND MD.</i>		25a. REC'D. BY REGISTRAR <i>WFO</i>	25b. REGISTRAR'S SIGNATURE <i>J. Charles J. George</i>
VIII A15 (4) 20 M 1/66		DATE <i>1966</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17394

CERTIFICATE OF DEATH

17385

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>MONTGOMERY</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b CITY OR TOWN (If outside corporate limits, write R-RAL and give nearest town) <b>SILVER SPRING</b>		c LENGTH OF STAY IN lb <b>11508 Idlewood Road</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11508 Idlewood Road</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Vera L. Hodges</b>		4. DATE OF DEATH Month <b>12</b> Day <b>20</b> Year <b>1966</b>	
S. SEX <b>F.</b>	6 COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-27-14</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <b>52 yrs</b>
			11 BIRTHPLACE (County & State or foreign country) <b>STANLEY - NC (CAROLINA)</b>
13. FATHER'S NAME <b>JAMES LINFORTE LEOWELL</b>		12 CITIZEN OF WHAT COUNTRY? Address <b>11508 Idlewood Road</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	17 INFORMANT <b>FRANK O. HODGES</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Disseminated Melanoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Melanoma</b>		6 mos.	
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) <b>Idlewood</b> (County) <b>Baltimore</b> (State) <b>Md.</b>
21. I certify that (I) (This hospital) attended the deceased from <b>5/11/66</b> to <b>12/20/66</b> , that (I) (we) last saw the deceased alive on <b>12/20/66</b> , and that death occurred at <b>9:00 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>G. Leonard Gold</b>		22b. DATE SIGNED <b>12/20/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. LEONARD GOLD</b>		22d. ADDRESS <b>8641 Coleridge Road, Silver Spring MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 23, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Taylor Cemetery</b>
24. FUNERAL DIRECTOR, ADDRESS <b>J. Arthur Walter, 254 Carroll St NW, DC</b>		25a. REC'D BY REGISTRAR, DATE <b>DEC 27 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Death Services</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

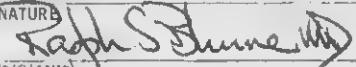
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

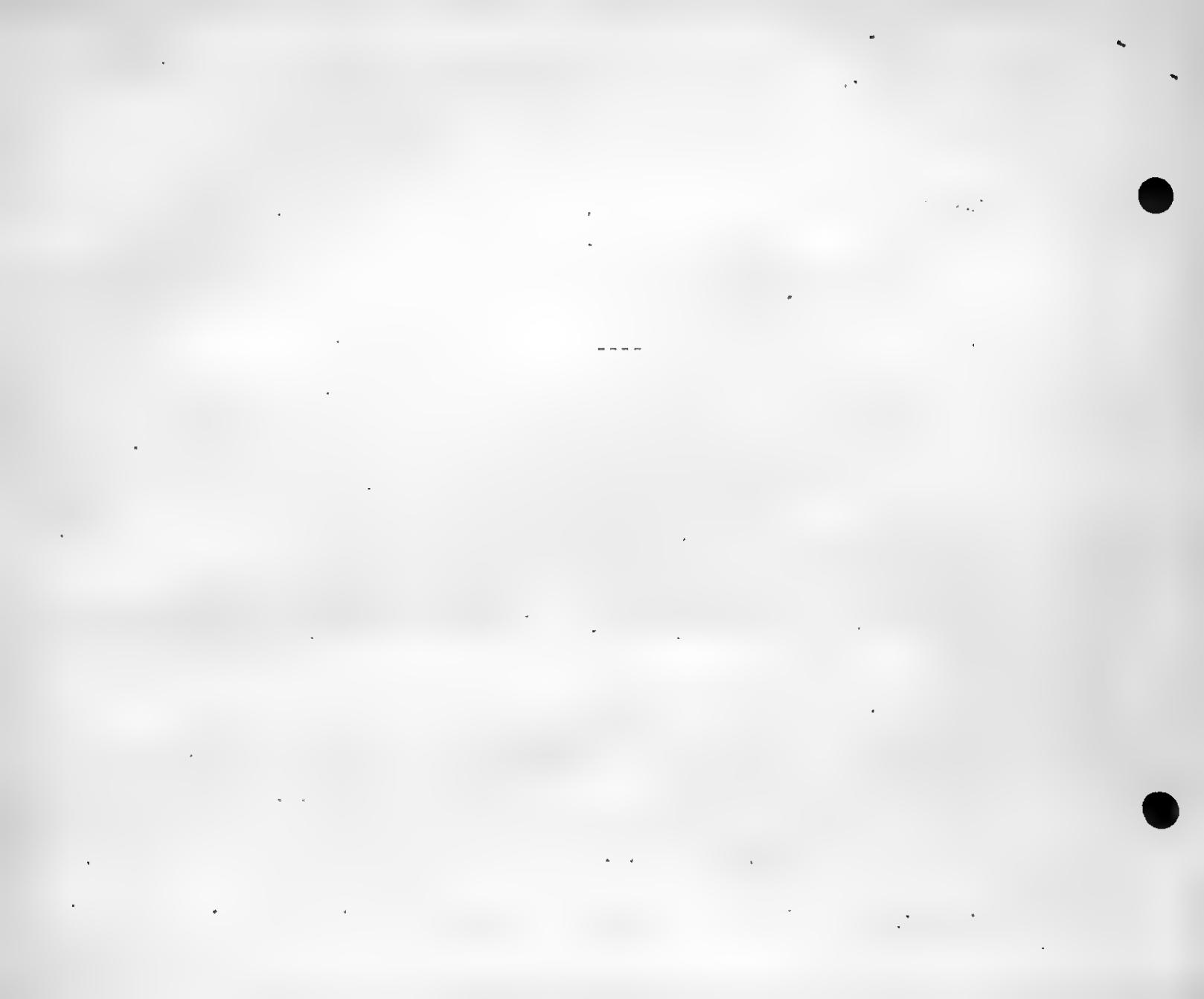
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17395

## CERTIFICATE OF DEATH

17386

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>North Carolina</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> 19 Days		b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Marion</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		d. STREET ADDRESS <b>Route 5, Box 250</b>	
3. NAME OF DECEASED (Type or print) <b>Alice Evelyn Holland</b>		4. DATE OF DEATH December 9 1966	
5. SEX <b>Female</b> White		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>8 October 1916</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Luther Lee</b>		14. MOTHER'S MAIDEN NAME <b>Rosie Robinson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY ND. None	
17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Md. 20014		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia with pericarditis and effusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic pyelonephritis</b>		unknown more than 6 months	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cardiac disease with decompensation - unknown etiology</b> /inactive <b>Chronic idiopathic ulcerative colitis, Cryptococcal meningitis, treated</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(s)</b> (this hospital) attended the deceased from <b>20 November, 1966</b> , to <b>9 December 1966</b> , that <b>(s)</b> (we) last saw the deceased alive on <b>9 December 1966</b> , and that death occurred at <b>10:20</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>December 10, 1966</b>	
22a. SIGNATURE 		P.M. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Ralph S. Blume, M.D.</b>		22d. ADDRESS National Institutes of Health, The Clinical Center, Bethesda, Md. 20014	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12-13-66</b>	
23c. NAME OF CEMETERY OR CREMATORIUM <b>Zion Hill Baptist Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Marion, North Carolina</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		25a. ADDRESS <b>BETHESDA, MARYLAND</b>	
25b. REC'D BY REGISTRAR <b>Charles Judge</b>		25d. REGISTRAR'S SIGNATURE	
DATE DEC 15 1966			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17396

CERTIFICATE OF DEATH

17387

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be retained by the hospital or attending physician. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN lb <b>20 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>15400 Bailey Lane</b>	
3. NAME OF DECEASED (Type or print) <b>James</b>		First	Middle <b>Milton</b>	Lost	4 DATE OF DEATH <b>12</b>	Month <b>28</b>	Day <b>19</b>	Year <b>66</b>	5 IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S. SEX <b>Male</b>	6 COLOR OR RACE <b>Colored</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>5/10/1884</b>	9 AGE (in years lost birthday) <b>82 yrs</b>		IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS Months <b>0</b>
10a. SUCIAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Yes</b>			
13. FATHER'S NAME <b>Thomas Holland</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Tucker</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Mont. Gen. Hosp. Records, Olney, Md.</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro vascular Hemorrhage</b> 331X DUE TO Candidias, if any, which gave rise to immediate cause (a), stating the underlying cause list. (b) <b>Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>28 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Uremia</b>						4 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Dec. 28, 1966</b>	(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <b>46</b> , to <b>Dec. 28, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 28 1966</b> , and that death occurred at <b>6:10PM</b> , from causes and on the date stated above									
22a. SIGNATURE <b>Richard A. Yates, M.D.</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <b>Richard A. Yates, M.D.</b>		22d. ADDRESS <b>Olney, Maryland</b>		22e. DATE SIGNED <b>12/29/66</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/31/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Ash Memorial</b>		23d. LOCATION (City or Town) <b>Sandy Spring, Mont. Md.</b>			
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, **Page 3** should be detached for use as the burial-transit permit. Then please remove carbon papers. **Pages 1 and 2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
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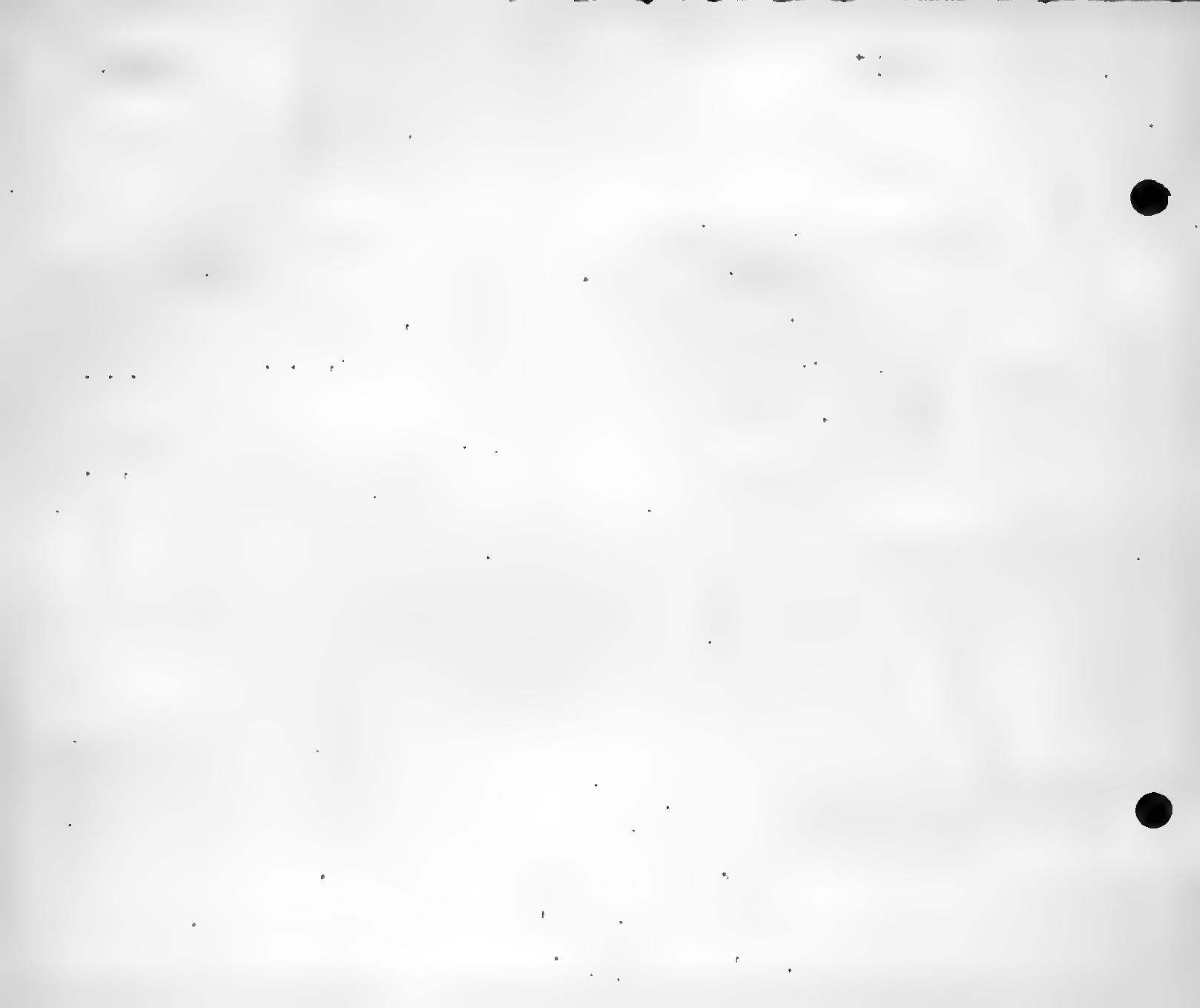
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17397

## CERTIFICATE OF DEATH

17388

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Potomac Manor Nursing Home</b>	
3. NAME OF DECEASED (Type or print) <b>George J. Hudson</b>		First	Middle
4. DATE OF DEATH Month Day Year <b>December 9 1966</b>		Last	Month Day Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>April 9, 1883</b>		9. AGE (In years if under 1 year, if under 24 hrs. last birthday) Months Days Hours Min. <b>83 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railway Express</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George J. Hudson</b>		14. MOTHER'S MAIDEN NAME <b>Curtin</b> Address <b>13111 Glen Mill Rd.</b> <b>Rockville, Md.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>WW 1</b>		16. SOCIAL SECURITY NO. <b>2</b>	17. INFORMANT <b>Mrs Virginia Simmons</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332 X</b> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <b>Diseases, &amp; c. H.P.T.</b>		OUE TO <b>cerebral Infarction</b>	
		(b) DUE TO <b>cerebral Thrombosis</b>	
		(c) DUE TO <b>cerebral Aneurysm</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diseases, &amp; c. H.P.T.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>21. I certify that (I) (this hospital) attended the deceased from <b>2/11/66</b> to <b>12/10/66</b>, that (I) (we) last saw the deceased alive on <b>12/9/66</b>, and that death occurred at <b>Rockville, Md.</b> from the causes and on the date stated above.</b>	
22a. SIGNATURE <b>Stephen N. Jones MD</b>		22b. DATE SIGNED <b>12/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>Rockville, Md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/12/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>St. Mary's</b>
24. FUNERAL DIRECTOR <b>1331 Rockville Pike, Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 15 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17398

## CERTIFICATE OF DEATH

17389

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <b>Maryland</b> Montgomery								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c LENGTH OF STAY IN 1b <b>38 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		d STREET ADDRESS <b>11609 Dewey Rd.</b>						
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>Allen</b>		First <b>Allen</b>	Middle <b>Stanley</b>	Last <b>Hufsmith</b>	4 DATE OF DEATH <b>December 13, 1966</b>						
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9/5/90</b>	9. AGE (In years last birthday) <b>76 yrs</b>	10. IF UNDER 1 YEAR Months <input type="checkbox"/>	11. IF UNDER 24 HRS Days <input type="checkbox"/>	12. Hours <input type="checkbox"/>	13. Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Brakeman</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>F. Lewis Hufsmith</b>			14. MOTHER'S MAIDEN NAME <b>Martha Miller</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>			16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <b>Mrs. Martha Wohlfarth item #2 daughter</b>			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>									INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease									many Years		
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <b>Bethlehem</b>	(County) <b>None</b>	(State) <b>None</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>11-5, 1966</b> , to <b>12/13, 1966</b> that (I) (we) last saw the deceased alive on <b>12/13, 1966</b> , and that death occurred at <b>3:00 PM</b> , from causes and on the date stated above.										22b. DATE SIGNED <b>12/14/66</b>	
22a. SIGNATURE <i>Richard H. Pollen</i>			M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) <b>RICHARD H. POLLON</b>			22d. ADDRESS <b>10400 CONNECTICUT AVE KENSINGTON MD</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/17/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Memorial Park</b>			23d. LOCATION (City or Town) <b>Bethlehem</b>			(County) <b>None</b>	(State) <b>None</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>			25a. ADDRESS <b>1991 Rock Pike Rockville, Md.</b>			25b. REC'D BY REGISTRAR <b>DEC 16 1966</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17399

## CERTIFICATE OF DEATH

17390

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			c. LENGTH OF STAY IN lb <b>7 Months</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Hall Nursing Home</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		
3 NAME OF DECEASED (Type or print) <b>ALICE</b>			4 DATE OF DEATH Month <b>DECEMBER</b> Day <b>1</b> Year <b>1966</b>		
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Aug. 26, 1891</b>	9. AGE (In years last birthday) <b>75</b> yrs.	10. IF UNDER 1 YEAR <b>3</b> Months 11. IF UNDER 24 HRS <b>5</b> Dofs Hours <b>Min</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>(Unknown) Burroughs</b>			14. MOTHER'S MAIDEN NAME <b>Amy Ricketts</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Daughter <b>Mrs. Dorothy J. King</b> Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 MIN.</b>					
DUE TO (b) <b>ESSENTIAL HYPERTENSION</b> — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> —					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. MEDICAL CERTIFICATION 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>PARKINSONS SYNDROME</b>					
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>(County)</b> <b>(State)</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL 4, 1966</b> , to <b>DEC. 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>DEC. 1, 1966</b> , and that death occurred at <b>4:45 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Henry M. Lowden</b>					
22c. PHYSICIAN'S NAME (Type) <b>HENRY M. LOWDEN</b>		22d. ADDRESS <b>5206 Narrows Dr. Chestertown, Maryland</b>		22b. DATE SIGNED <b>12/1/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-5-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Cedar Hill Cemetery</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		23d. LOCATION (City or Town) <b>Suitland, Maryland</b>		(County) <b>(State)</b>	
				25a. REC'D BY REGISTRAR <b>Judge</b>	
				25b. REGISTRAR'S SIGNATURE <b>Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17400

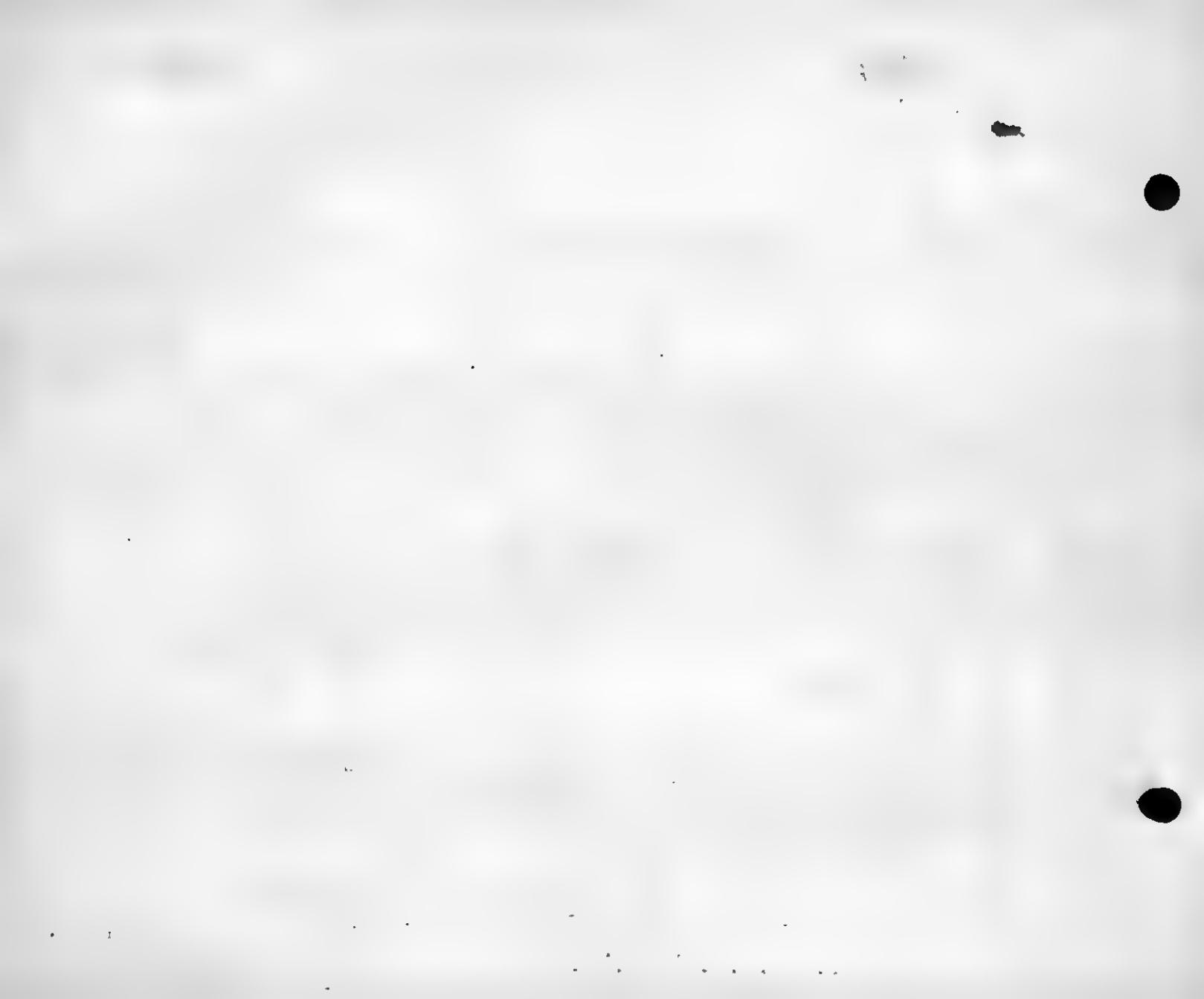
CERTIFICATE OF DEATH

17391

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN lb <b>3 mo.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				d. STREET ADDRESS <b>1712 Gridley Lane</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>CHARLES</b>	Middle <b>H.</b>	4. DATE OF DEATH <b>JENKINS</b>	Month <b>Dec.</b>	Day <b>4</b>	Year <b>1966</b>
S SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <b>WIDOWED</b>	NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>3/12/80</b>	9. AGE (In years lost birthday) <b>86 yrs.</b>	10. UNDER 1 YEAR Months <b>0</b>	11. UNDER 24 HRS Days <b>0</b>
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>merchant</b>			11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD.</b>	
13. FATHER'S NAME <b>CYPRIAN JENKINS</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE ULRICH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>578 44 5318</b>		17. INFORMANT <b>MILDRED A. JENKINS (DAUGHTER)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b>				DUE TO <b>Archael Thrombosis</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Arteriosclerosis</b>				DUE TO <b></b>			
				DUE TO <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from causes and on the date stated above.							
22o. SIGNATURE <b>William Jenkins</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/4/66</b>			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-7-1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring Md.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc</b>		ADDRESS <b>5130 Wisconsin Ave. N.W. Wash. DC.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE	
VR A15 (4) 20 M 1/66				DATE <b>DEC 8 1966</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17392

17401

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
<i>Montgomery Maryland</i>		Md Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1B <i>15 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cabin John</i>	
f. STREET ADDRESS <i>#4 Webb Road</i>		g. 5 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ralph</i>		4. DATE OF DEATH Month Day Year <i>12-21 1966</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>Gr</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-19-1891</i>	
9. AGE (In years to birthday) <i>75 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>res. govt.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>A.S.A.</i>	
13. FATHER'S NAME <i>William Jenkins</i>		14. MOTHER'S MAIDEN NAME <i>Laura Grimes</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>577-18-2746</i>	
17. INFORMANT <i>Margaret Stream - Cabin John Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>rupture abdominal aortic aneurysm</i> DUE TO <i>451X</i> INTERVAL BETWEEN ONSET AND DEATH <i>04-13</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerosis</i> DUE TO <i>451X</i> (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>malnutrition</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-1 1966</i> to <i>21 Dec 1966</i> , that (I) (we) last saw the deceased alive on <i>90 Dec 1966</i> , and that death occurred on <i>11 Dec 1966</i> , M, from causes and on the date stated above.		22b. DATE SIGNED <i>21 Dec 66</i>	
22a. SIGNATURE <i>John M. Wyman</i>		22c. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>John M. Wyman</i>		22d. ADDRESS <i>Norfolk Building Bethesda, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-23-66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Taylorstown Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Taylorstown, Virginia</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS REC'D BY REGISTRAR <i>DEC 27 1966</i>	
		REGISTRAR'S SIGNATURE <i>John M. Wyman</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17402

## CERTIFICATE OF DEATH

17393

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

11 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				b. COUNTY <b>Prince Georges</b>				
c. LENGTH OF STAY IN lb <b>14 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Heights 20028</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>				d. STREET ADDRESS <b>3323 Roslyn Avenue</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3 NAME OF DECEASED (Type or print)		First <b>Ruth</b>	Middle <b>Ann</b>	Last <b>Johnson</b>	4. DATE OF DEATH <b>December 22</b>	Month <b>December</b>	Day <b>25</b>	Year <b>1966</b>
S SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>22 December 1915</b>	9 AGE (In years last birthday) <b>51 yrs</b>	IF UNDER 1 YEAR Months <b>51</b>	IF UNDER 24 HRS Days Hours Min. <b>00 00 00</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11 BIRTHPLACE (County & State or foreign country) <b>North Carolina</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Davis</b>				14. MOTHER'S MAIDEN NAME <b>Susan Hail</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>239-10-3215</b>		17. INFORMANT The Medical Record's Address <b>The Clinical Center, Bethesda, Md. 20014</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hemorrhage</b> DUE TO 203X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Pancytopenia</b> DUE TO (c) <b>Multiple Myeloma</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Ulcerative colitis with hemorrhage</b> <b>Staphylococcal Pneumonia and /</b> <b>Septicemia</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>FAYETTEVILLE</b>	(County) <b>N.C.</b>	(State) <b>-N.C.-</b>		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11 December 1966</b> to <b>25 December 1966</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>25 December 1966</b> , and that death occurred at <b>12:30 PM</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>Leroy Fass, M.D.</b>				M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>12/15/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leroy Fass, M.D.</b>				22d. ADDRESS National Institutes of Health, <b>The Clinical Center, Bethesda, Md. 20014</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-29-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>CROSS CREEK</b>	23d. LOCATION (City or Town) <b>FAYETTEVILLE - N.C.</b>		(County) <b>N.C.</b>	(State) <b>-N.C.-</b>	
24. FUNERAL DIRECTOR JOSEPH BAWLER & SONS, INC. ADDRESS <b>5130 - WISCONSIN AVE. N.W. WASH. D.C.</b>				25a. REC'D BY REGISTRAR DATE JAN 3 - 1967		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17403

## CERTIFICATE OF DEATH

17394

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN b <i>22 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>	
3. NAME OF DECEASED (Type or print) <i>IDA</i>		d. STREET ADDRESS <i>2113 Henderson Ave.</i>	
First <i>KATHLEEN</i>		Middle <i>JONES</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/10/19</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	11. BIRTHPLACE (County & State or foreign country) <i>Raleigh, North Carolina</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>William A. Watkins</i>		14. MOTHER'S MAIDEN NAME <i>Vienna Marshburn</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No/None</i>		16. SOCIAL SECURITY NO. <i>237-22-7582</i>	17. INFORMANT <i>Gordon C. Jones</i>
		Address <i>2113 Henderson Ave. Wheaton, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <i>5810</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Congestive Liver with Bleeding Esophageal Varix 4 years</i>	
IMMEDIATE CAUSE (a) <i>5810</i>		DUE TO (b) DUE TO (c)	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>10620 Georgia Avenue, S. S., Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>5/20/62</i> to <i>12/12/66</i> , that (I) (we) last saw the deceased alive on <i>12/12/66</i> , and that death occurred at <i>10620 Georgia Avenue, S. S., Md.</i> from causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE <i>John J. Curry</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/12/66</i>
22c. PHYSICIAN'S NAME (Type) <i>John J. Curry</i>		22d. ADDRESS <i>10620 Georgia Avenue, S. S., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 15, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Parklawn Cemetery</i>
24. FUNERAL DIRECTOR <i>John B. Thomas</i>		ADDRESS <i>John B. Thomas, 8434 Georgia Ave., Silver Spring, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 16 1966</i>
24. FUNERAL DIRECTOR <i>Charles E. Murphy, Inc.</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1 M

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay occurs, execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMs. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-trait permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17404 17395

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>4003 Hampden St.</i>		d. STREET ADDRESS <i>4003 Hampden St.</i>	
3. NAME OF DECEASED First <i>George</i> Middle <i>Albert</i>		4. DATE OF DEATH Month <i>12</i> Day <i>24</i> Year <i>1966</i>	
5. SEX <i>Male</i> 6. COLOR OR RACE <i>Negro</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>6-23-07</i> 9. AGE (In years last birthday) <i>59</i> yrs.		10. KIND OF BUSINESS OR INDUSTRY <i>Laborer</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Andrew Joppy</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>Berketta Joppy</i> Address <i>Item #2</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO <i>Obstructive Heart Failure</i>	
		DUE TO <i>Arteriosclerotic Heart Disease.</i>	
		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cirrhosis of Liver - Diabetes Mellitus</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Redap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>BELDEN R. REDAP M.D.</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, City, Town, or County) <i>Wheaton</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> 12/28/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Ash Memorial</i>	
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>		23d. LOCATION (City, town or county) (State) <i>Sandy Spring, Md.</i>	
		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
		DATE JAN 3 1967	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #3 Film #3364 17397 pc

17405

## CERTIFICATE OF DEATH

17397

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5100 Dorset Avenue</b>		d. STREET ADDRESS <b>5100 Dorset Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Carrie) (Type or print)	First <b>CAROLYN</b>	Middle <b>J.</b>	Last <b>KEKENES</b>
4. DATE OF DEATH <b>12-18-1966</b>	Month Year Day Year	12-18-1966 19 19 19	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>9-12-1885</b>		9. AGE (In years last birthday) <b>81 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY — — —	
11. BIRTHPLACE (County & State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Pechmann</b>		14. MOTHER'S MAIDEN NAME <b>Julia Gratzick</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-50-0483</b>	
17. INFORMANT		Address <b>Chevy Chase, Julia C. Kekenes, 5100 Dorset Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <i>Hypertension arterios claretic</i>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<i>Heart Disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>left Renal tumor (type undetermined).</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>While at work</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 1964</b> to <b>12/18 1966</b> , that (I) (we) last saw the deceased alive on <b>12/17 1966</b> , and that death occurred at <b>155A M</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>12/18/66</b>	
22a. SIGNATURE <b>J. Blaine Fitzgerald</b>		22b. ADDRESS <b>8218 Wisconsin Ave. Bethesda.</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Blaine Fitzgerald</b>		22d. ADDRESS <b>8218 Wisconsin Ave. Bethesda.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-20-1966</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Glenwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Joseph Lawler's Sons, Inc.</b>		ADDRESS <b>5130 Wisc. Ave. N.W. Wash. DC.</b>	
25a. REC'D BY REGISTRAR DATE <b>DEC 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Wiley Judy.</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17306

## CERTIFICATE OF DEATH

Reg. Dist. No.

17398

**TO HOSPITAL:** The [law requires that the death certificate be executed within 24 hours] general director, may be retained.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland		b. COUNTY		Montgomery	
Montgomery				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Boyd's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Olney		c. LENGTH OF STAY IN lb		15 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Montgomery General Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
		Eugene	Milheim	Keller	Dec.	23	19	66			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
Male	White	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	6-1-98	68 yrs.	Months	Days	Hours	Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY?					
Carpenter				Pa.		USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Elliott Keller		Elizabeth Milheim									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address					
No		388-07-25634		Mollie McGuire Keller, Boyd's, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1302		CEEBRAL EDEMA		2-3 Days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)	DUE TO	BRONCHOPNEUMONIA, CLINICAL 1-2 DAY							
		(c)		ASTROCYTOMA, CEREBRAL MALIGNANT 6-8 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED?					
HYPERTENSION		RIGHT : CRANIAL NERVE PALSY				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)					
21. I certify that I attended the deceased from 12/7/66 to 12/23/66, 1966, that I last saw the deceased alive on 12/23/66, and that death occurred at 4:10 AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED					
ACTUAL SIGNATURE		Dr. Donald Lewis M.D.		Medical Center		12/23/66					
PHYSICIAN'S NAME (Type)				Olney, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)				
Burial		12/26/66	Monocacy		Bellefonte		Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D. BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE						
William B. Heller Barnstable, Md				DEC 28 1966	William J. ...						



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**17407**

### CERTIFICATE OF DEATH

**17399**

Item 8 Form 6-204

**1. PLACE OF DEATH**

COUNTY

Maryland  
City or Town (If outside corporate limits, write RURAL and give nearest town)

MARYLAND

c. LENGTH OF STAY IN 1b

3 weeks

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Hospital license - This is not -  
1st & 2nd floors

e. NAME OF DECEASED  
(Type or print)

First Middle Last

Charles Charles Kemp

f. SEX

Male W

g. COLOR OR RACE

WIDOWED  DIVORCED

h. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

i. FATHER'S NAME

George George

j. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or date of service)

No

k. MARRIED  NEVER MARRIED

l. DATE OF BIRTH

1883 July 13, 1881

m. KIND OF BUSINESS OR INDUSTRY

n. BIRTHPLACE (County & State, or foreign country)

Frederick, Md

o. MOTHER'S MAIDEN NAME

Charles Zimmerman

p. SOCIAL SECURITY NO.

920-44-8757

q. INFORMANT

Rev. Ward Kemp - Highland, Md.

r. ADDRESS

Highland, Md.

s. INTERVAL BETWEEN  
INJURY AND DEATH

5 days

t. 2 yrs

18. CAUSE OF DEATH (Enter only one cause for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY;  
IMMEDIATE CAUSE (a)

DUE TO

Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause inst. (b)

DUE TO

cause inst. (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 19

p.m.

White  Not White

at work  at work

20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

9/19 1966

20e. (City or town)

12/17/66

(County)

Howard Co.

(State)

MD.

22a. SIGNATURE

Charles S. Whitaker,

M.D.

ATTENDING PHYS.

X

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

12/17/66

22c. PHYSICIAN'S NAME (Type)

CHAS. S. WHITAKER, M.D.

CLARKSBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

12-20-66

23b. DATE THEREOF

12-20-66

23c. NAME OF CEMETERY OR CEMETORY

OAK Grove Cemetery

23d. LOCATION (City, town or county)

Howard Co.

(State)

MD.

24 FUNERAL DIRECTOR'S SIGNATURE

Harry W. Haught

Sykesville, Md.

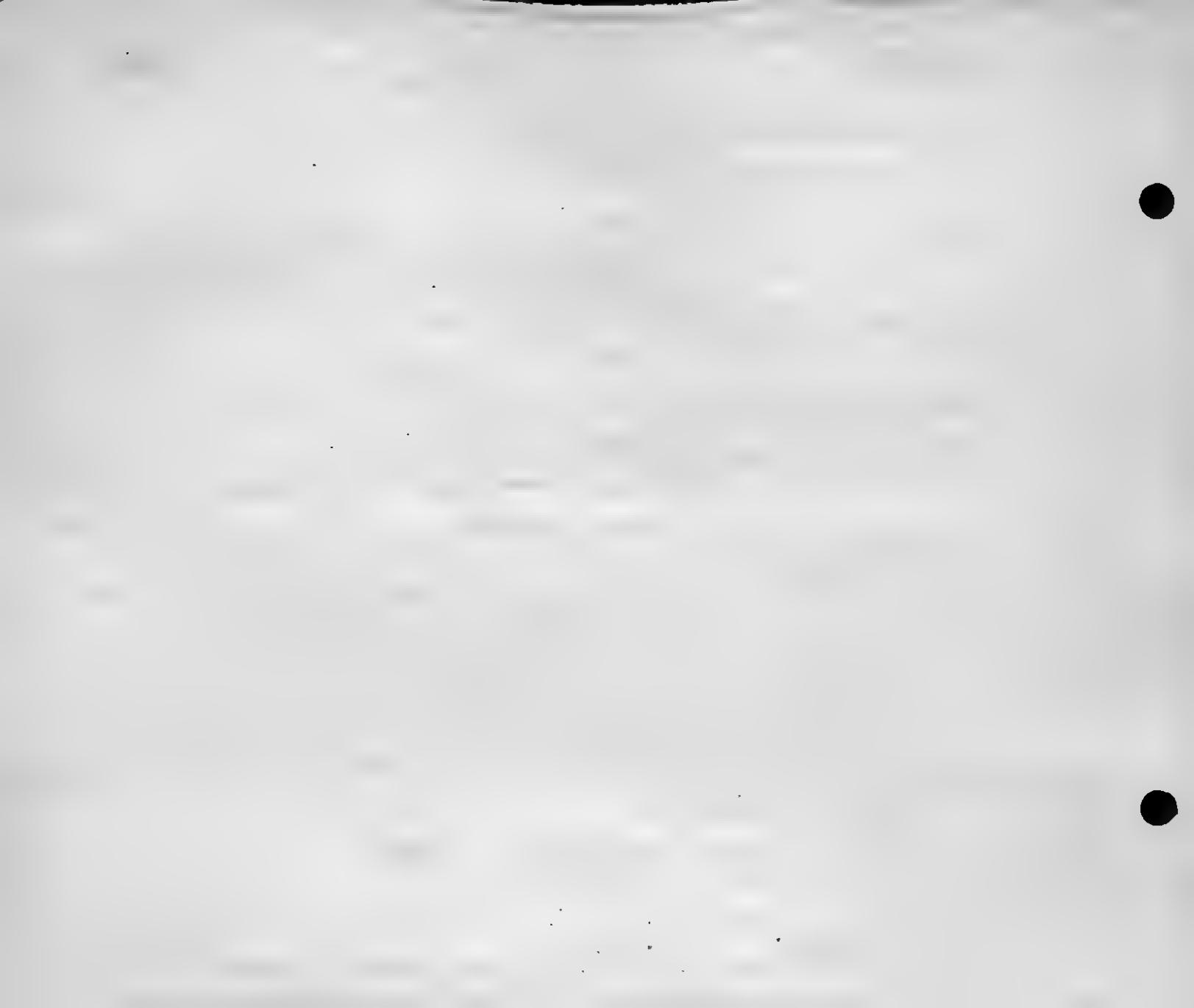
ADDRESS

25a. REC'D BY REGISTRAR

DEC 23 1966

25b. REGISTRAR'S SIGNATURE

REG. 12/23/66



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17408

CERTIFICATE OF DEATH

17408

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN lb <b>13 days</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN</b>			e. STREET ADDRESS <b>7812 GLENBROOK ROAD</b>		
3. NAME OF DECEASED (Type or print) <b>BENJAMIN HARRISON KENNEDY</b>			4. DATE OF DEATH Month Day Year <b>Dec. 9 19 66</b>		
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>3/1 1889</b>	9. AGE (In years last birthday) <b>77 yrs</b>	10. IF UNDER 1 YEAR Months Days Hours Min. <b>0 0 0 0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret'd.) <b>Furniture Mfg.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New York, (Monroe Co)</b>	
13. FATHER'S NAME <b>John Wellington Kennedy</b>			14. MOTHER'S MAIDEN NAME <b>Katherine Henhom</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>128-07-4738</b>		17. INFORMANT Address <b>Linnie Kennedy (Same as above)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia, diffuse</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic Cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>		
DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Advanced Rheumatic arthritis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>Dec 12, 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 1, 19 66</b> , to <b>THE DAY OF DEATH</b> , that (I) (we) last saw the deceased alive on <b>12-9 19 66</b> and that death occurred at <b>5322 M</b> , from causes and on the date stated above.			22b. DATE SIGNED <b>12-10-66</b>		
22a. SIGNATURE <b>Edward Youngblood</b>			ATTENDING MED STAFF MD PHYS DIRECTOR PHYS 22b. DATE SIGNED <b>12-10-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Edward J. Youngblood</b>		22d. ADDRESS <b>Jashington Clibic Wash., D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 12, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>			23e. RECEIVED BY REGISTRAR <b>Charles J. Geiger</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. Geiger</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

17409

## CERTIFICATE OF DEATH

17401

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>11 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY <i>Montgomery</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>				d. STREET ADDRESS <i>2320 Glenmont Circle</i>				
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Louise</i>		First <i>Louise</i>	Middle <i>Marie</i>	Last <i>Klein</i>	4. DATE OF DEATH Month <i>Dec.</i>	Day <i>27</i>	Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>12-13-98</i>	9. AGE (In years last birthday) yrs <i>68</i>	IF UNDER 1 YEAR Months Days Hours Min.		
10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Koch</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i> <i>None</i>				16. SOCIAL SECURITY NO <i>182-32-8214</i>				
17. INFORMANT <i>John George Walter</i>				Address <i>2320 Glenmont Circle Silver Spring, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>465X</i> DUE TO <i>Pulmonary Embolism massive</i> INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Gastric ulcer &amp; bleeding massive</i>								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (brief nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <del>the hospital</del> attended the deceased from <i>12-16-66</i> , 19 <i>66</i> , to <i>12-27</i> , 19 <i>66</i> , that (I) <del>we</del> last saw the deceased alive on <i>12-27</i> , 19 <i>66</i> , and that death occurred at <i>11602 Ga. Ave., S.S., Md.</i> from causes and on the date stated above.		22a. SIGNATURE <i>Morris Perry</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12-27-66</i>		
22c. PHYSICIAN'S NAME (Type) <i>Morris Perry, M.D.</i>		22d. ADDRESS <i>11602 Ga. Ave., S.S., Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 30, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co., Md.</i>		
24. FUNERAL DIRECTOR <i>Thomas J. Warner E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17410

## CERTIFICATE OF DEATH

17402

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>PRINCE GEORGES</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>		c. LENGTH OF STAY IN lb <i>2 DAYS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HILLCREST HEIGHTS</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>3334 CURRIS DR. S.E.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>BETTY</i>	Middle <i>LEE</i>	Last <i>KLENK</i>	4. DATE OF DEATH <i>12 - 5</i>	Month <i>12</i>	Day <i>- 5</i>	Year <i>1966</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>11/28/24</i>	9. AGE (In years last birthday) <i>42 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SECRETARY</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. TREASURY DEPT.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>ROANOKE, VA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>FRANK E. STRAUSS</i>		14. MOTHER'S MAIDEN NAME <i>VIVIAN LEE LITES</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>HOSPITAL RECORDS</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X</i>		cerebral hemorrhage				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) <i>thrombocytopenia</i>					
		DUE TO (c) <i>adenocarcinoma of breast</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>ROANOKE</i>		20f. (City or town) (County) (State) <i>ROANOKE</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>5/65</i> , to <i>12/5</i> , 1966, that (I) (we) last saw the deceased alive on <i>12/4</i> , 1966, and that death occurred at <i>M</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>G. Lennard Gold</i>		MD ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>12/15/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>G. Lennard Gold, M.D.</i>		22d. ADDRESS <i>8641 Colesville Rd., Silver Spring, Md.</i>					
23a. BURIAL/CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE THEREOF <i>12/5/1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>SHERWOOD CEM.</i>		23d. LOCATION (City or Town) (County) (State) <i>ROANOKE</i>	
24. FUNERAL DIRECTOR <i>Joseph Hawkins, Jr.</i>		ADDRESS <i>5130 Wisconsin Ave. N.W.</i>		25a. RECD BY REGISTRAR <i>DEC 8 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17418

**CERTIFICATE OF DEATH**

17403

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Gaithersburg	
Gaithersburg				d. STREET ADDRESS		211 Cedar Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		211 Cedar Ave.		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Alice	Middle Knibbs	Last	4. DATE OF DEATH December	Month	Day Year
5. SEX Female		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/1877	9. AGE (in years last birthday) 89 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
Housewife							
13. FATHER'S NAME Z. Wm. McAtee		14. MOTHER'S MAIDEN NAME Virginia Purdum					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 578-50-9904		17. INFORMANT Evelyn W. Selby--sister--same item		Address 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>33IX</u> Cerebral Vascular Accident. INTERVAL BETWEEN ONSET AND DEATH One Month							
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u>							
DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/26/66</u> , 19 <u>66</u> , to <u>12/18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/28</u> , 19 <u>66</u> , and that death occurred at <u>A. M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Luciano J. Leal</u> 22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Luciano J. Leal</u>		22d. ADDRESS <u>Gaithersburg Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/30/66</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home Rockville, Md.</u>		ADDRESS <u>Rock. Pike</u>		25a. REC'D BY REGISTRAR <u>ULU</u> DATE <u>1500</u>		25b. REGISTRAR'S SIGNATURE <u>J. J. J.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

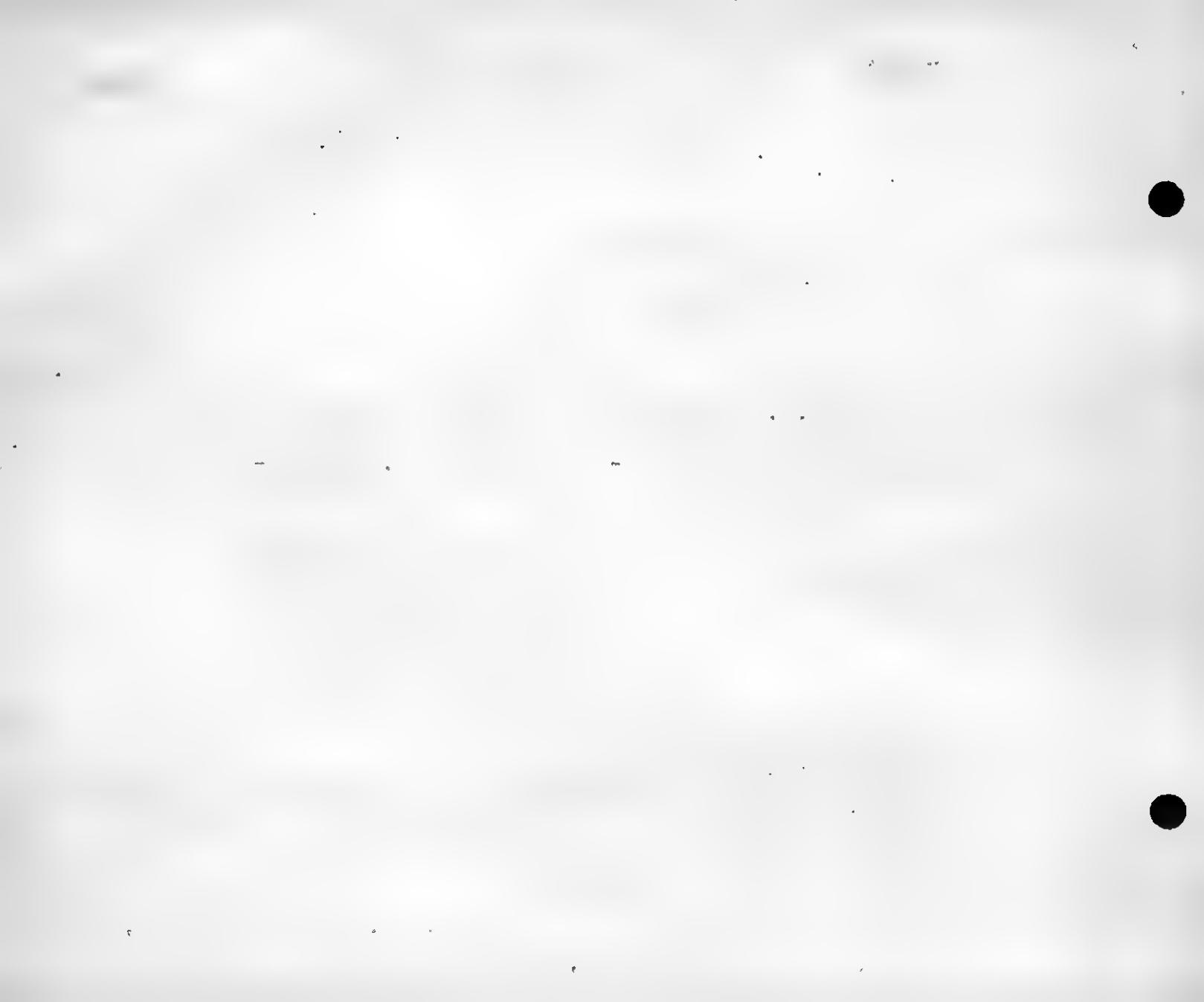
17512

CERTIFICATE OF DEATH

17404

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, removal, or removal.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>Pennsylvania</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reading</i>			
3. NAME OF DECEASED (Type or print) <i>Mary B. Nikirk</i>		4. DATE OF DEATH <i>12-17</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-8-92</i>	9. AGE (In years last birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Melvin A.E. Biser</i>		14. MOTHER'S MAIDEN NAME <i>Esta Nikirk</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>194-07-3448</i>		17. INFORMANT Daughter Address 439 Penn Ave. <i>Margaret K. Seidel -Sinking Spring, Pa.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>cardiac arrest</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c)		<i>acute myocardial infarction</i>		3 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>12/14</i> , 19 <i>66</i> , to <i>12/17</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/16</i> , 19 <i>66</i> , and that death occurred at <i>11:35 AM</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>Marvin Wadler</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/17/66</i>		
22c. PHYSICIAN'S NAME (Type) <i>MARVIN WADLER</i>		22d. ADDRESS <i>8218 Wisconsin Av. Bethesda, Md.</i>			
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial-transit</i>		23b. DATE THEREOF <i>12-18-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Sinking Spring, Cem.</i>	23d. LOCATION (City or Town) <i>Sinking Spring, Penna.</i>	(County) (State)
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 22 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17413

## CERTIFICATE OF DEATH

17405

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If out's de corporate limts, write RURA, and give nearest town) <i>Bethesda, Md.</i>		c. LENGTH OF STAY IN TO <i>Suburbans</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kensington</i>		e. STREET ADDRESS <i>4512 Everett St.</i>	
3. NAME OF DECEASED (Type or print) <i>Chas Los Edward Knott</i>		4. DATE OF DEATH <i>Dec. 23 1966</i>	
S SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Jan. 12 1908</i>		9. AGE (In years at birthday) <i>58 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Delivery post office dist. of Col. U.S.A.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Catharine Farrelle</i>	
13. FATHER'S NAME <i>John Edward Knott</i>		14. MOTHER'S MAIDEN NAME <i>Catharine Farrelle</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO <i>Louise C. Knott</i>	
17. INFORMANT <i>Wife</i>		Address <i>Same as Item 2.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion, see in Hypertensive ASHD</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Generalized Atherosclerosis</i>			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>2 mo.</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Diabetes Mellitus. Pulmonary Emphysema</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>(City or town) (County) (State)</i>
21. I certify that (I) (this hospital) attended the deceased from <i>10 Dec. 1966</i> , to <i>23 Dec. 1966</i> , that (I) (we) last saw the deceased alive on <i>23 Dec. 1966</i> , and that death occurred at <i>8:30 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>R. F. Cresswell, Jr.</i>		22b. DATE SIGNED <i>12-23-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. F. Cresswell, Jr.</i>		22d. ADDRESS <i>2029 Quo St. N.W., Washington, D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-27-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven</i>
23d. LOCATION (City or Town) <i>Silver Spring, Maryland</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS ADDRESS <i>120 M 1/66</i>	
		25a. REC'D BY REGISTRAR <i>DEC 30 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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17414

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Item 1-Phone call by 1/16/66 mnb

17406

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased resided, if institutional residence before admission)	
WASHINGT MARYLAND		a. STATE D.C.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c LENGTH OF STAY IN TD-	b. COUNTY	
WASHINGT - CHEVY CHASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. 12130 RIBBLEMAN 7602 Connecticut		d. STREET ADDRESS Washington	
e. VENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First SORRY	Middle	Last KOITA
4 DATE OF DEATH	Month Dec	Day 13	Year 1966
5 SEX M	6. COLOR OR RACE colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DIVORCED <input type="checkbox"/> W DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/12/1966
9 AGE (In years last birthday) yrs. 9/1		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Africa	
12 CITIZEN OF WHAT COUNTRY? Africa		13. FATHER'S NAME Amadou	
14. MOTHER'S MAIDEN NAME Aissata Bocoum		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Washington D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Castro Enteritis - Acute -		INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		DUE TO	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Bell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/13/66		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12/15/66	
23c NAME OF CEMETERY OR CREMATORIAL ADDRESS National Mem. Park		23d LOCATION (City or Town) (County) (State) Falls Church, Virginia	
24 FUNERAL DIRECTOR ADDRESS St. Thomas Co 2901 14th St. W.		25a. REC'D BY REGISTRAR DATE DEC 16 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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17415

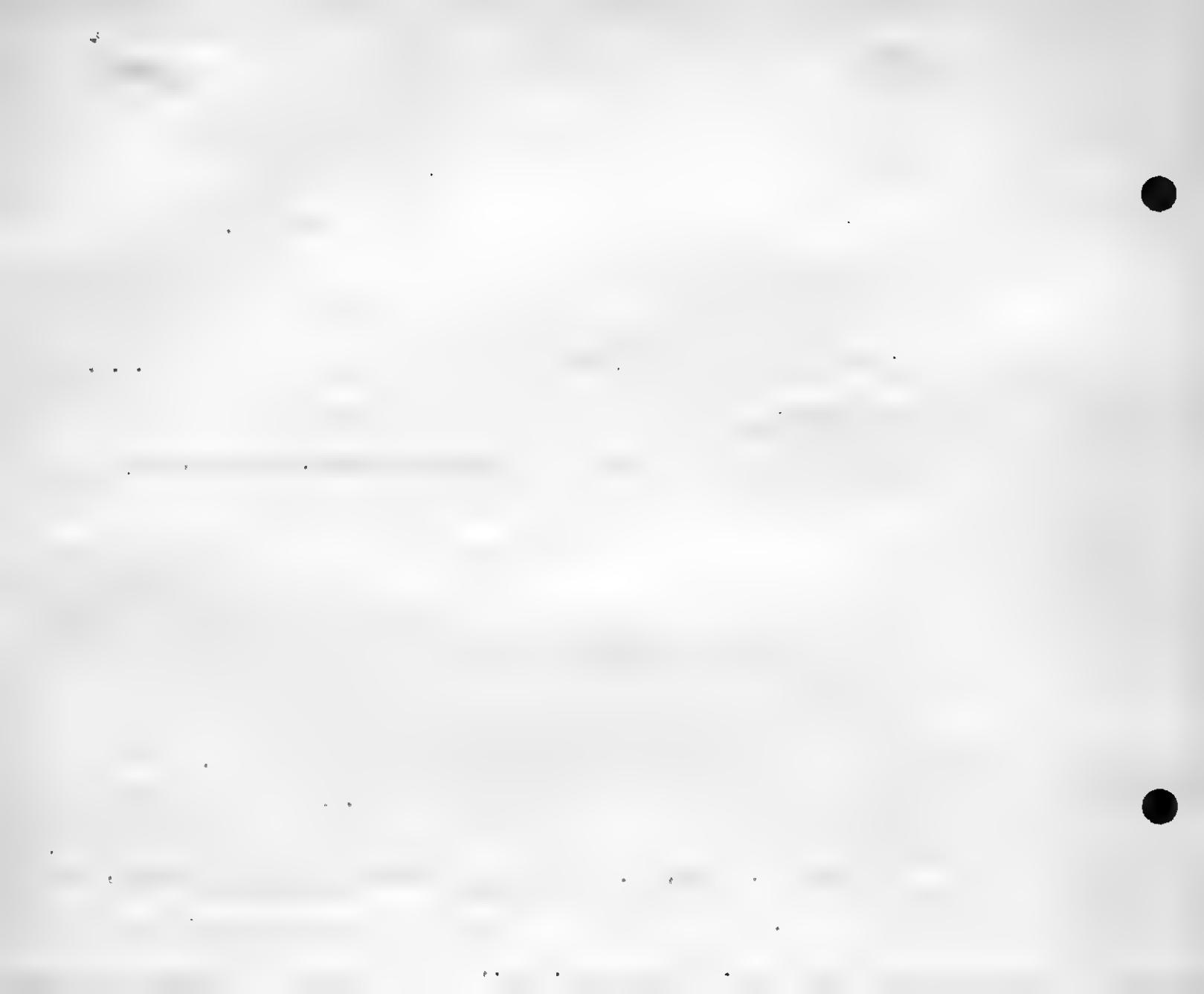
## CERTIFICATE OF DEATH

17407

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**11 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~please remove carbon paper. Pages 1 and 2~~ remove carbon paper. ~~within 72 hours after death~~

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN b <b>114 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. STREET ADDRESS <b>816 Taylor Street, N.E.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
g. DATE OF DEATH <b>December 1966</b>		Month <b>December</b>	Day <b>19</b> Year <b>1966</b>
3 NAME OF DECEASED (Type or print)	First <b>Dawn</b>	Middle <b>Marie</b>	Last <b>Langdon</b>
4 SEX <b>Female</b>	5 COLOR OR RACE <b>White</b>	6 MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7 NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>1961</b>	9. AGE (In years last birthday) <b>5 yrs.</b>	10. IF UNDER 1 YEAR Months <b>5</b>	11. IF UNDER 24 HRS Days <b>Hours</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Langdon</b>		14. MOTHER'S MAIDEN NAME <b>Joan Harrell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda, Maryland</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral lobar pneumonia</b> DUE TO <b>Gram negative septicemia</b> DUE TO <b>Acute Lymphocytic Leukemia</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Acute Renal failure- probably drug induced</b>		5 Days	
2 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute Renal failure- probably drug induced</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>27 August, 1966, to 19 Dec., 1966, that (s) (we) last saw the deceased alive on 19 Dec., 1966, and that death occurred at 3:45 P.M. from causes and on the date stated above.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>
20f. (City or town) <b>A.M.</b>		(County) <b>19 December 1966</b>	
(State)			
21. I certify that (s) (this hospital) attended the deceased from 27 August, 1966, to 19 Dec., 1966, that (s) (we) last saw the deceased alive on 19 Dec., 1966, and that death occurred at 3:45 P.M. from causes and on the date stated above.		22b. DATE SIGNED	
22c. SIGNATURE <b>Myron J. Levin</b>		A.M.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.		22b. DATE SIGNED <b>19 December 1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 22-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>
23d. LOCATION (City or Town) <b>Arlington, Virginia</b>		(County) <b>Virginia</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros. 1661-Gd. Hope Road SE. Wash., DC</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1966</b>	
ADDRESS <b>Simmons Bros. 1661-Gd. Hope Road SE. Wash., DC</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Simmons</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17416

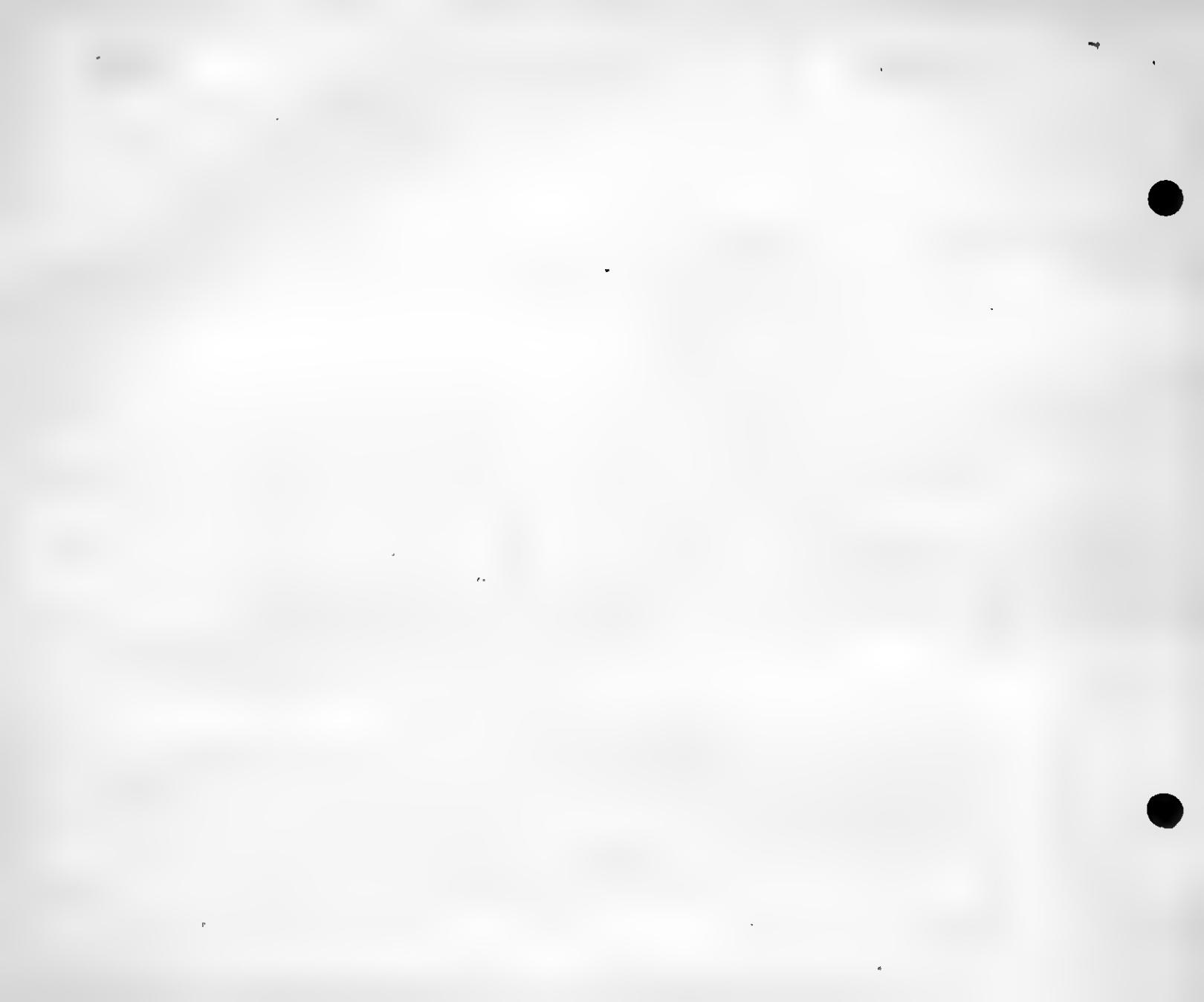
CERTIFICATE OF DEATH

17408

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>DC District of Columbia</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>5474-31st St N.W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Julia</b>		First	Middle <b>M.</b>	Last <b>LANGE</b>	4. DATE OF DEATH Month <b>Dec</b>	Day <b>12</b>	Year <b>1966</b>
S SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-5-81</b>	9. AGE (In years last birthday) <b>85 yrs.</b>	10. UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <b>Retired - Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Tromsø, Norway</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ole Melland</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO <b>220-54-0363</b>		17. INFORMANT <b>4830 Leland St. Ch. Ch., Maryland</b>		Address <b>Mrs. Ralph Hickerson - (daughter)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b>		DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Acute Cholecystitis with rupture and sub hepatic abscess</b>		DUE TO (b) <b>7 days</b>					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/29/66</b> , to <b>12/12/66</b> that (I) (we) last saw the deceased alive on <b>12/12/66</b> , and that death occurred at <b>12/12/66</b> P.M., from causes and on the date stated above.							
22a. SIGNATURE <b>Frank Y. Jagger Jr. MD</b>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED <b>12-12-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>FRANK Y. JAGGERS JR.</b>		22d. ADDRESS <b>5707 WISCONSIN AVE</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-16-66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Natl Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
				DATE			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

17417 17109

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Montgomery				b. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Wheaton		1 year		Silver Spring, Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
University Nursing Home, 901 Arcola Ave, Wheaton, Md.		6305 Landon Lane 9800 Rockville Rd., Silver Spring, Md.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Willy Boteler				Lee	Dec. 19 1966
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		White		8. DATE OF BIRTH	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Mar. 23, 1882	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Housewife - wife		Own Home		84 yrs.	
13. FATHER'S NAME		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Edward M. Boteler		Washington, D.C.		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		yes Mr. Hoburg R. Lee	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Thrombosis		1 d.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Arteriosclerosis		?	
DUE TO		DUE TO		DUE TO	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour a.m. p.m. 19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		(City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, to _____, 19____, that (I) (we) last saw the deceased alive on 14 Dec 1966, and that death occurred at 5:30 A.M. the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED	
William D. Lund		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		12-19-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		9006 Colesville Rd. Silver Spring	
Aud, William - M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		Dec. 21, 1966		23c. NAME OF CEMETERY OR CREMATORIAL	
24. FUNERAL DIRECTOR		ADDRESS		23d. LOCATION (City, town or county) (State)	
John B. Thomas, J. B. Thomas & Son, Inc.		8434 Georgia Ave. Silver Spring, Md.		Rockville, Maryland	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE	
Lil		Lil		150b	



FOR STATE  
HEALTH DEPT.

17418

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17410

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <i>Maryland</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b COUNTY <i>Montgomery</i>	
c LENGTH OF STAY IN lb		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8625 Piney Br Rd</i>		d STREET ADDRESS <i>8625 - Piney Br. Rd.</i>	
3 NAME OF DECEASED (Type or print) <i>Miriam Judith Levin</i>		4 DATE OF DEATH <i>12 - 12 1966</i>	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5 SEX <i>Female</i>		6 COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>11-15-09</i>		9. AGE (In years last birthday) <i>57</i>	F UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SECRETARY</i>		10b KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>
13. FATHER'S NAME <i>JACOB WEINTROB</i>		14. MOTHER'S Maiden Name <i>RACHEL FRIEDMAN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>150-09-5901</i>	17. INFORMANT <i>Miriam Levin</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420/</i>		Address <i>2629 Pioneer Lane Falls Church, VA</i>	
DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part o or Part l of item 1b)	
20c TIME OF INJURY Month, Day Year Hour o.m. p.m. <i>19</i>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Lepp</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>BELDEN R. LEPP M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>Dec. 12, 1966</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b DATE THEREOF <i>12-14-66</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>NAT'L Memorial Park</i>
23d LOCATION (City or Town) (County) (State)		23e	
24 FUNERAL DIRECTOR ADDRESS <i>Grosvenor Funeral Home 4217 Georgia Ave. N.W.</i>		25a REC'D BY REGISTRAR DATE <i>DEC 19 1966</i>	
25b REG STRR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

*17419*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. *Then please remove carbon papers.* *Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.*

*Cleared with medical Examiner (Dr. Repp) mg*

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>N.Y.</b>		b. COUNTY <b>QUEENS</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN lb <b>1d</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Flushing, L.I.</b>		d. STREET ADDRESS <b>13270 Sanford Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington San. 9<sup>th</sup> Hosp.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Rosa</b>	Middle <b></b>	Lost <b>Lindheimer</b>	4. DATE OF DEATH Month <b>12</b>	Day <b>21</b>	Year <b>1966</b>
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JAN 9 1886</b>	9. AGE (in years lost birthday) <b>85 yrs</b>	10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS Days <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HSWF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>Amer</b>	
13. FATHER'S NAME <b>Philip Greiner</b>		14. MOTHER'S MAIDEN NAME <b>Louise Lesser</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO <b>UNKNOWN</b>	
17. INFORMANT <b>Hospital Record</b>		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Acute myocardial infarction</b>		DUE TO (b)	DUE TO (c)	<b>Pulmonary edema &amp; heart failure</b>		<b>36 hrsp</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-20, 1966</b> , to <b>12-21, 1966</b> , that (I) (we) last saw the deceased alive on <b>12-21, 1966</b> , and that death occurred at <b>1045 1/2</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Morril C. Quinnam</b>		.M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12-21-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Morril C. Quinnam, Jr.</b>		22d. ADDRESS <b>831 Univ. Blvd., E., Sil. Spr. Md.</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-23-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>CYPRESS HILLS Cem.</b>	23d. LOCATION (City or Town) <b>BROOKLYN</b>			
24. FUNERAL DIRECTOR <b>GOLDBERG FUNERAL HOME</b>		ADDRESS <b>2407-8</b>	25a. REC'D BY REGISTRAR <b>REC'D - 100B</b>	25b. REGISTRAR'S SIGNATURE <b>12-23-66</b>			
		DATE					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17420

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17412

1. PLACE OF DEATH  
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits  
write RURAL and give nearest town)

Silver Spring D.C.A.

c. LENGTH OF STAY IN ID

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Holy Cross Hospital

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

5. SEX

6. COLOR OR RACE

Cauc.

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

4. DATE  
OF  
DEATH

Month

Day

Year

DEC. 17 1966

e. IS RESIDENCE  
ON A FARM?  
YES  NO

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Med. Sec'y.

10b. KIND OF BUSINESS OR INDUSTRY

M.D.'s OFFICE

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

37

yrs.

10. UNDER 1 YEAR

Months

0

Days

0

Hours

0

11. UNDER 24 HRS

Minutes

0

Seconds

0

13. FATHER'S NAME

Benjamin Dayhoff

14. MOTHER'S MAIDEN NAME

Geneva Wolfe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO. / 17. INFORMANT

220-26-0592

Address

#2

B. Frank Lushbaugh - Husband - same item

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

???

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

OUT TO

(b)

DUE TO

(c)

Multile, extreme,  
internal injuries with  
Exsanguination

INTERVAL BETWEEN  
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS

PRIMARY  OR CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Injuring object, driving vehicle, fall, etc., to

vegetable, curve and struck phone pole.

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 12 17 1966

p.m. 12 17 1966

20d. INJURY OCCURRED

While at work  Not while at work

et work

20e. PLACE OF INJURY (Home, farm, factory, street, off. or bldg., etc.)

Street

20f. (City or town) (County)

Montgomery Co., Md.

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion

death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

*Belden K. Kucia*

BELDEN K. KUCIA, M.D.

CHIEF MEDICAL EXAMINER   
M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22. DATE SIGNED

12/17/1966

23a. BURIAL, CREMATION, REMOVAL (Specify)

Cremation

23b. DATE THEREOF

12/19/66

23c. NAME OF CEMETERY OR CREMATORIUM

Bedar Hill Cemetery

23d. LOCATION (City, town or county) (State)

Prince George Co., Md.

24. FUNERAL DIRECTOR

Tyson Wheeler Funeral Home

ADDRESS

1331 Rockville Pike

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DEC 22 1966

Charles Judge

the first time when  
I was in the  
United States

on

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17421

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or embalming.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
<i>Montgomery</i>		a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	b. COUNTY <i>Montgomery</i>	
<i>Bethesda</i>	<i>DoA</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARMS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>Sukhman</i>	<i>135 Southbrook Ln</i>		
3. NAME OF DECEASED (Type or print)	First <i>Edwa</i>	Middle <i>L.</i>	4. DATE OF DEATH Month <i>Dec.</i> Day <i>6</i> Year <i>1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-13-1908</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>WASH. D.C.</i>	9. AGE (In years last birthday) <i>58 yrs</i>
13. FATHER'S NAME <i>HENRY B.</i>	14. MOTHER'S MAIDEN NAME <i>MARY ELLEN STEHLE</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>None</i>	17. INFORMANT Husband <i>Frank C. Maley</i>	Address <i>Same as Item 2.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Yellow Jaundice</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Chronic</i> lost. (c) <i>Jaundice</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic Cardiac Disease. Regurg.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <i>9/5/66</i> , 19 <i>66</i> , to <i>12/4/66</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/1/66</i> , 19 <i>66</i> , and that death occurred at <i>12/4/66</i> M, from causes and on the date stated above.		22b. DATE SIGNED <i>12/16/66</i>	
22a. SIGNATURE <i>Henry C. Scruggs Jr.</i>		ATTENDING M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>HENRY C. SCRUGGS</i>		22d. ADDRESS <i>5413 Cedar Lane Bethesda, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-9-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Glenwood Cemetery</i>	23d. LOCATION (City or Town) <i>Washington, D.C.</i> (County) <i>D.C.</i> (State)
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15 (4) 20 M 1/66	DATE <i>DEC 9 1966</i>		



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

PAGE 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17422

## CERTIFICATE OF DEATH

17416

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>				
b. CITY OR TOWN (If outside corporate lim.ts., write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>80 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEV CHASE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>			d. STREET ADDRESS <b>2932 TERRACE DRIVE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>ALBERT</b>	Middle <b>V.H.</b>	Lost	4. DATE OF DEATH <b>12-19-66</b>	Month Year 19	Day	
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11-22-14</b>	9. AGE (In years lost birthday) <b>52 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHYSICIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NAVAL RESEARCH LAB</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAM MASKET</b>			14. MOTHER'S MAIDEN NAME <b>TILLY ELIAS</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. — — —		17. INFORMANT <b>BETTY H. MASKET SAME AS #2 c&amp;d</b>			
Address						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leiomyosarcoma</b>							
DUE TO <b>197.9</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8</b> , 19 <b>66</b> , to <b>12/19</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/19/66</b> , and that death occurred at <b>11:59 AM</b> , from causes and on the date stated above.						22b. DATE SIGNED <b>12/16/66</b>	
22a. SIGNATURE <b>G. Lennard Gold</b>			22b. ADDRESS <b>8641 COLSVILLE RD. SIL. SP..MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>12/22/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>CEDAR HILL CREMATORIAL</b>		23d. LOCATION (City or Town) (County) (State) <b>PRINCE GEO. CO., MD.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH G. MILLER'S SONS, INC.</b>			ADDRESS			25a. REC'D BY REGISTRAR DATE <b>OCT 23 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Judge</b>
VR A15 (4) 20 M 1/66							



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17423

CERTIFICATE OF DEATH

17414

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tahoma Park</i>		c. LENGTH OF STAY IN lb <i>9 hours</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>735 Shilo Avenue, No. 307</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First <i>Olindo</i>	Middle <i>(None)</i>	Last <i>Marsaglio</i>	4. DATE OF DEATH Month <i>December</i>	Year <i>25 1966</i>	5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-10-90</i>	9. AGE (In years last birthday) <i>76 yrs</i>	F. UNDER 1 YEAR Months <i>Days</i>	IF UNDER 24 HRS Hours <i>Min</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Minister</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						
13. FATHER'S NAME <i>Emilio C. Marsaglio</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Cilento</i>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO <i>Unknown</i>		17. INFORMANT <i>Records - Washington Sanitarium &amp; Hospital</i>		Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hypertension</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Arteriosclerotic Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i>										
(b) DUE TO <i>Arteriosclerotic Cardiovascular Disease</i>		-- yrs.										
(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Dec. 25 1966</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from Dec. 25, 1966 to Dec. 25, 1966, that (I) (we) last saw the deceased alive on Dec. 25, 1966, and that death occurred at 2:52 P.M. from causes and on the date stated above.												
22a. SIGNATURE <i>Gene U. Cohen, M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Dec. 25, 1966</i>						
22c. PHYSICIAN'S NAME (Type) <i>Gene U. Cohen, M.D.</i>		22d. ADDRESS <i>1106 SPRING ST. SILVER SPRING, MARYLAND</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/28/66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co. Md.</i>						
24. FUNERAL DIRECTOR <i>The S. H. Hines Company Washington, DC</i>		ADDRESS		25a. REC'D. BY REGISTRAR DATE <i>DEC 25 1966</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>						



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17424

CERTIFICATE OF DEATH

17415

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c LENGTH OF STAY IN lb <b>11 days</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d STREET ADDRESS <b>1732 27th St., S. E.</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>Patricia</b>		First	Middle	Lost	4 DATE OF DEATH <b>December 9 1966</b>	Month	Day Year	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 22, 1894</b>	9. AGE (In years last birthday) <b>72 yrs</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steward</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Philippine Islands</b>		
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>				16. SOCIAL SECURITY NO <b>-1947</b>	17. INFORMANT <b>Washington, D. C.</b> Address <b>Mrs. Ann G. Martinez, 1732 27th St., S.E.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>443X</b>				DUE TO (b) <b>Hypertension</b>				
DUE TO (c) <b>Cardiac Insufficiency</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <b>(this hospital)</b> attended the deceased from <b>Nov. 22, 1966</b> to <b>Dec. 9, 1966</b> , that <b>(we)</b> lost saw the deceased alive on <b>Dec. 9, 1966</b> , and that death occurred at <b>1230AM</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>R. E. Bullock</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>Dec. 9, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>R. E. BULLOCK LT., MC, USN</b>				22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 18-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR <b>Mattingly Funeral Home</b> 131 11th St., S. E., Washington, D. C.				25a. REC'D BY REGISTRAR DATE <b>DEC 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17425

CERTIFICATE OF DEATH

17417

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. LENGTH OF STAY IN b <i>6 days</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>			
3 NAME OF DECEASED (Type or print) <i>Gregory B. Mason</i>				d. STREET ADDRESS <i>113 Oxford St.</i>			
e. SEX <i>M</i>		f. COLOR OR RACE <i>W</i>		g. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		h. DATE OF DEATH <i>10/13/66</i>	
i. 10a. USUAL OCCUPATION (Give kind of work done during regt of working life, even if retired) <i>SALES REP.</i>		i. 10b. KIND OF BUSINESS OR INDUSTRY <i>BUILDING</i>		j. 11. BIRTHPLACE (County & State, or foreign country) <i>MICHIGAN</i>		k. 9. AGE (In years last birthday) <i>64 yrs</i>	
l. 13. FATHER'S NAME <i>Heber Mason</i>				m. 14. MOTHER'S MAIDEN NAME <i>Ada Gregory</i>			
n. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		o. 16. SOCIAL SECURITY NO <i>214-16-7000</i>		p. 17. INFORMANT <i>MARGARET V. MASON</i>		q. Address <i>SAME 2 C.&amp;D</i>	
r. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Anemia + Benignal Encysted Cystic</i> DUE TO <i>Small hemangioblastoma</i> 48 hr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Depression of liver due to tumor</i> 48 hr (c) <i>Obstruction of bile duct</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bleeding Esophageal varices, Diarrhoea, Cholelithiasis</i>							
s. 20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		t. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
u. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Oct. 17, 1966</i>		v. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		w. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		x. 20f. (City or town) (County) (State) <i>Prince George Co., MD</i>	
y. 21. I certify that (I) (the hospital) attended the deceased from <i>Oct. 17, 1966</i> , to <i>Dec. 17, 1966</i> , that (I) (we) last saw the deceased alive on <i>Dec. 17, 1966</i> , and that death occurred at <i>M</i> , from causes and on the date stated above.							
z. 22a. SIGNATURE <i>Donald Clark</i>				aa. 22b. DATE SIGNED <i>1352 York Blvd.</i>			
bb. 22c. PHYSICIAN'S NAME (Type) <i>Harold Springer MD</i>		cc. 22d. ADDRESS <i>5130 Wisconsin Ave. N.W. WASH., D.C.</i>					
dd. 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		ee. 23b. DATE THEREOF <i>12/20/66</i>		ff. 23c. NAME OF CEMETERY OR CREMATORIAL <i>CEDAR HILL CREMATORIAL</i>		gg. 23d. LOCATION (City or Town) (County) (State) <i>PRINCE GEO. CO., MD</i>	
hh. 24. FUNERAL DIRECTOR ADDRESS <i>JOSEPH GAWLER SON'S 5130 WISCONSIN AVE. N.W.</i>		ii. 25a. REC'D BY REGISTRAR <i>Charles Judge</i>		jj. 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		kk. DATE <i>DEC 23 1966</i>	



1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17426		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						17418			
1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>								
c LENGTH OF STAY IN b. <b>DCA</b>			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>								
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hosp.</b>			d. STREET ADDRESS <b>11208 Buckwood Lane</b>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print)		First <b>Dwight</b>	Middle <b>Merrick</b>	Last <b>McCallum</b>	4 DATE OF DEATH <b>Dec - 15 - 1966</b>		Month Year	Day	Year		
5 SEX <b>M.</b>	6 COLOR OR RACE <b>W-</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>May 6, 1904</b>	9 AGE (In years lost birthday) <b>62 yrs</b>	10 IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		11 IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>				
12 DO USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Emergency Planning</b>			13 FATHER'S NAME <b>Dwight Merrick McCallum, Sr.</b>			14 MOTHER'S MAIDEN NAME <b>Mabel Blatchley</b>			15 CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>Yes - Army War II</b>			17 SOCIAL SECURITY NO <b>107-09-4771</b>			18 INFORMANT <b>Wife</b>			19 Address <b>Same as Item 2.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4</b> <b>Cardiac Vascular Disease -</b> DUE TO (b) <b>Years.</b> (c)			20 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			22. DATE SIGNED <b>12/15/66</b>		
20a MEDICAL CERTIFICATION EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f (City or town) <b>Bethesda</b> (County) <b>Md.</b> (State) <b>Md.</b>		21. ACTUAL SIGNATURE <b>John G. Ball</b>			22. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>12-19-66</b>		23c NAME OF CEMETERY OR CREMATORIUM <b>Arlington Natl Cem.</b>		23d LOCATION (City or Town) <b>Arlington</b> (County) <b>Virginia</b> (State)					
24 FUNERAL DIRECTOR <b>ROBERT A. PUNPHREY, Bethesda, Maryland</b>		25a ADDRESS		25b REC'D BY REGISTRAR		25c REG STRA'S SIGNATURE <b>Charles Judge</b>					
DATE <b>DEC 22 1966</b>											



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17427

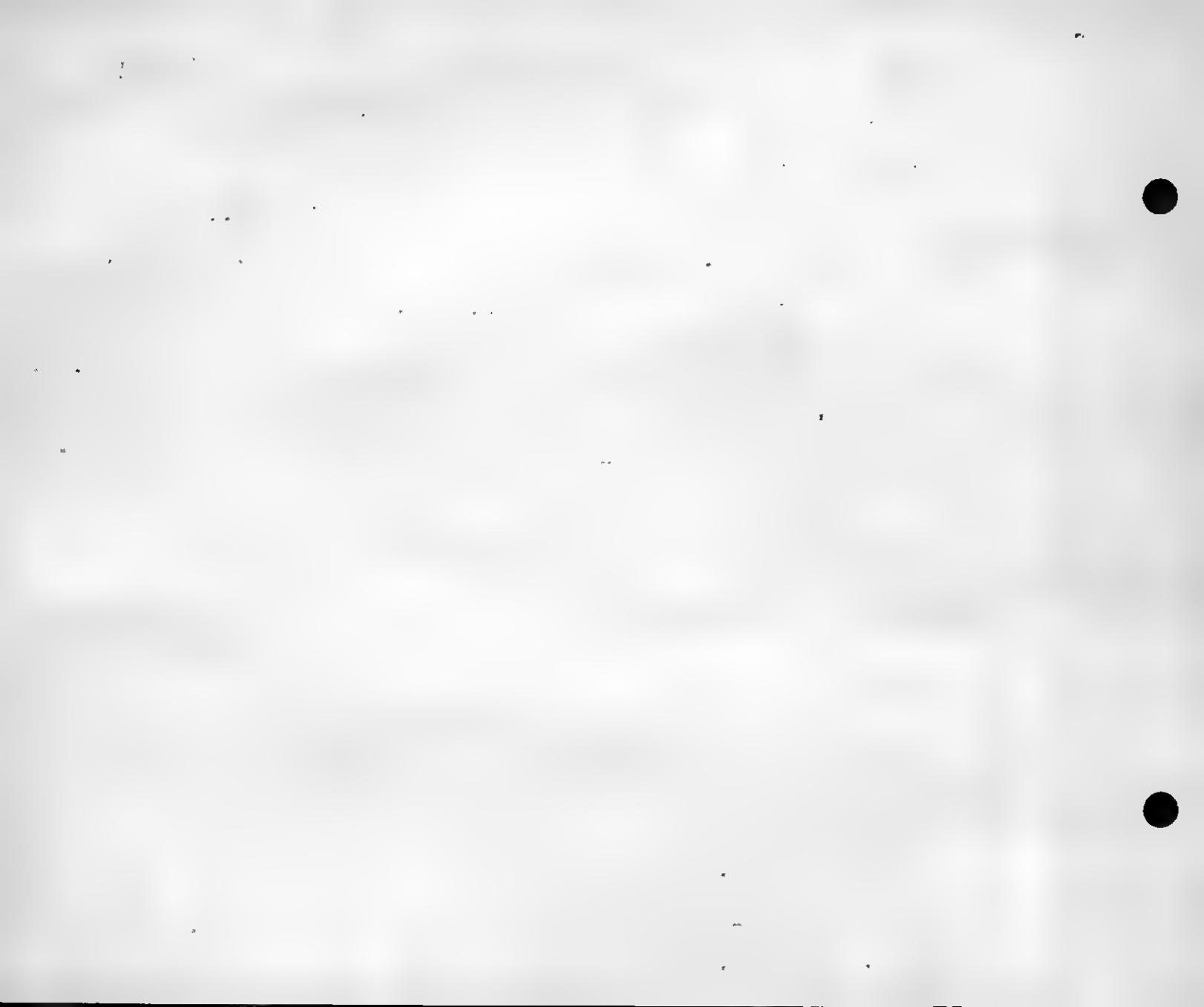
CERTIFICATE OF DEATH

17419

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN b. <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>			d. STREET ADDRESS <b>11504 Elkins St., # 2</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED First <b>Robert</b> Middle <b>E.</b> Last <b>McConnell</b>			4. DATE OF DEATH Month <b>11</b> , Day <b>December</b> , Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6, July, 13</b>	9. AGE (In years lost birthday) <b>53 yrs</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Equipment Specialist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Govt</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Edward S. McConnell</b>			14. MOTHER'S MAIDEN NAME <b>Olive Murman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW II</b>			16. SOCIAL SECURITY NO <b>272-01-5347</b>	17. INFORMANT Wife <b>Dorothy McConnell</b>	Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute Myocardial Infarction</b> INTERVAL BETWEEN ONSET AND DEATH <b>initial</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Pleuritic calcifications with Aortic dissection</b> , 2 Yrs stating the underlying cause (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 1966</b> , 19, to <b>12-11</b> , 1966, that (I) (we) last saw the deceased alive on <b>12/3</b> , 1966, and that death occurred at <b>M</b> , from causes and on the date stated above.						22b. DATE SIGNED <b>12-11-66</b>
22c. PHYSICIAN'S NAME (Type) <b>RICHARD B. PERRY</b>			22d. ADDRESS <b>8220 Cindy Lane Bethesda, Maryland</b>	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-14-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS	25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



MARYLAND STATE DEPARTMENT OF HEALTH  
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CERTIFICATE OF DEATH

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**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH <i>Montgomery Co.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY <i>5705 - Germantown Dr., Rockville, Md.</i>		a. STATE <i>Same</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville, Md.</i>		b. COUNTY <i>Montgomery Co., Md.</i>	
c. LENGTH OF STAY IN U.S. <i>1 year</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>None</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>M. Catherine McCormack</i>		d. STREET ADDRESS <i>5705 McCormick Cremation Dr.</i>	
e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED <i>M. Catherine McCormack</i>		4. DATE OF DEATH <i>Dec 5-1966</i>	
5. SEX <i>F.</i>		6. COLOR OR RACE <i>W.</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-30-1904</i>	
WIDOWED <input type="checkbox"/>		9. AGE (in years last birthday) <i>62 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (County & State or foreign country) <i>Phila. Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>None</i>	
13. FATHER'S NAME <i>John J. Keenan</i>		14. MOTHER'S MAIDEN NAME <i>Mary Agnes Keenan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>James &amp; McCormick Cremation Dr.</i>		Address <i>5705 McCormick Cremation Dr.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiovascular collapse</i> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH <i>several days</i></span>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral infarction due to cerebral embolism</i> <span style="float: right;">2-3 days</span>			
DUE TO (c) <i>Arteriosclerotic heart disease and atrial fibrillation</i> <span style="float: right;">many years</span>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Previous cerebral infarction from cerebral embolism</i>		19. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i> p.m. <i>None</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) <i>None</i> (County) <i>None</i> (State) <i>None</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>November 1966</i> , to <i>Dec 5, 1966</i> , that (I) (we) last saw the deceased alive on <i>Dec 5, 1966</i> , and that death occurred at <i>2:45 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>George H. Nuttall</i>		22b. DATE SIGNED <i>Dec 5, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>None</i>		22d. ADDRESS <i>None</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-7-1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Gates of Heaven</i>		23d. LOCATION (City or Town) <i>Wheaton, Md.</i> (County) <i>None</i> (State) <i>None</i>	
24. FUNERAL DIRECTOR <i>Timothy Hanlon 4748-Wisc Ave NW</i>		ADDRESS <i>None</i>	
25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>DEC 16 1966</i>			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17421

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington.</b>		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9701 Cable Drive.</b>	
e. STREET ADDRESS <b>9701 Cable Drive</b>		f. S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Joseph Walter McIntyre</b>		First <b>W</b>	Middle <b>Walter</b>
Last <b>McIntyre</b>	4 DATE OF DEATH Month <b>Dec</b> Day <b>11</b> Year <b>1966</b>		
S SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DIVORCED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH <b>Aug. 9, 1910</b>
9 AGE (In years last birthday) <b>56 yrs</b>	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Administrative Ass't</b>	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) <b>Mass.</b>
12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	13. FATHER'S NAME <b>Richard J. McIntyre</b>		
14. MOTHER'S MAIDEN NAME <b>Jennie Eva O'Toole</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes. WW II</b>
16. SOCIAL SECURITY NO <b>579-40-5035</b>			17. INFORMANT Wife <b>Dorothy S. McIntyre</b> Address <b>Same as Item 2.</b>
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Second.</b>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20c PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Bethesda, Md.</b>	
23a BURIAL/CREMATION, REMOVAL (Specify) <b>Burial-transit 12-14-66</b>		23b. DATE THEREOF <b>12-14-66</b>	
23c NAME OF CEMETERY OR CREMATORIAL <b>St. John's Cath. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Lancaster, Mass.</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS 25a. REC'D BY REGISTRAR DATE <b>DEC 14 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17430

CERTIFICATE OF DEATH

17422

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	c. LENGTH OF STAY IN b. <b>4 yrs</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Gardens Sanitarium</b>		d. STREET ADDRESS <b>1369 Hamilton Street, N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>MARY</b>	First <b>H.</b>	Middle <b>McPheeters</b>	Last <b>12</b> Month <b>19</b> Day <b>1966</b> Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH <b>7/18/1880</b>	9. AGE (In years last birthday) <b>86 yrs</b>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			11. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ROBERT McPheeters</b>		14. MOTHER'S MAIDEN NAME <b>Melissa P. Speck</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>578-30-6466</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Generalized arteriosclerosis.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days.</b>	
(b) <b>Generalized arteriosclerosis.</b> DUE TO (c)		years.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town) <b>Annapolis</b> (County) <b>Anne Arundel</b> (State) <b>Md.</b>	
21. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>Jan. 12/17, 1966</b> , to <b>12/17, 1966</b> , that <b>(1)</b> (we) last saw the deceased alive on <b>12/17, 1966</b> , and that death occurred at <b>5 A.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>James R. Coleman MD</b>		22b. DATE SIGNED <b>12/19/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES R. COLEMAN</b>		22d. ADDRESS <b>9241 COLUMBIA BLVD SILVER SPRING MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12/21/66</b>	
		23c. NAME OF CEMETERY OR CREMATORIAL <b>Bethel Presbyterian Church Cemetery Middlebrook</b>	
24. FUNERAL DIRECTOR		ADDRESS <b>The J.H. Kline Co. 2961 14th St. NW</b>	
		25a. REC'D BY REGISTRAR <b>REC'D 12/21/66</b>	
		25b. REGISTRAR'S SIGNATURE <b>Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17431

CERTIFICATE OF DEATH

17428

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		b. COUNTY <b>MONTGOMERY</b>	
c. LENGTH OF STAY IN b. <b>18 months</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>UNIVERSITY NURSING HOME 901 BRECKA + UNIVERSITY BLVD.</b>		d. STREET ADDRESS <b>1802 Sherwood Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>FRANCES</b>	Middle <b>ELIZABETH</b>	Last <b>McQuown</b>
S SEX <b>FEMALE</b>	6 COLOR OR RACE <b>Cau.</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Jan. 32, 1876</b>		9 AGE (In years last birthday) <b>90 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State or foreign country) <b>GREEN CO., PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES RAYANT CLEMENTS</b>		14. MOTHER'S MAIDEN NAME <b>RACHAEL HORN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>NO None</b>		16. SOCIAL SECURITY NO <b>yes</b>	
17. INFORMANT <b>Mr. DONALD E. McQuown</b>		Address <b>1802 Sherwood Rd. SILVER SPRING</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
Myocardial infarction			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>Dec. 22, 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <b>Claysville Cemetery</b>
20f. (City or town) <b>Claysville</b>		(County) <b>Pennsylvania</b>	(State) <b>PA</b>
21. I certify that (1) (this hospital) attended the deceased from <b>12-18-66</b> , to <b>12-18-66</b> , that (1) (we) last saw the deceased alive on <b>12-18-66</b> , and that death occurred at <b>9 AM</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>12-18-66</b>	
22a. SIGNATURE <b>D.L. Bucy / Spokes</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. ADDRESS <b>809 Veins Mill Rd Rockville MD</b>
22c. PHYSICIAN'S NAME (Type) <b>D.L. Bucy</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 22, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Claysville Cemetery</b>
24. FUNERAL DIRECTOR <b>Joh. B. Thrasier Warrier E. Pumfrey, Inc.</b>		ADDRESS <b>1177 Georgia Ave., Silver Spring, MD</b>	25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>
		25b. DATE <b>DEC 27 1966</b>	26b. REGISTRAR'S SIGNATURE <b>William J. Bucy</b>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17432

CERTIFICATE OF DEATH

17424

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>132 Days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>New Jersey</b>		b. COUNTY <b>Somerset</b>	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Basking Ridge</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				d. STREET ADDRESS <b>129 West Oak Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dolores Mary McVaugh</b>		First	Middle	Last	4. DATE OF DEATH <b>December 17 1966</b>	Month	Day	Year	
S SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 February 1920</b>	9 AGE (in years last birthday) <b>46 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John F. Housman</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Coles</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Not Available</b>		17. INFORMANT <b>The Medical Record</b> , Address <b>The Clinical Center, Bethesda, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>		
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b>			DUE TO <b>deformity and mitral insufficiency</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Heart disease undetermined etiology with septal</b>			(b) DUE TO <b>unknown</b>						
			(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Monoclonal gammopathy ? Myeloma</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7 August 1966</b> to <b>17 December 1966</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>17 December 1966</b> , and that death occurred at <b>12:45 AM</b> from causes and on the date stated above.									
22a. SIGNATURE <b>Rob Roy MacGregor</b>			M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>December 17, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Rob Roy MacGregor, M.D.</b>			22d. ADDRESS <b>National Institutes of Health, The Clinical Center, Bethesda, Md. 20014</b>						
23a. BUR AL, CREMATION, REMOVAL (Specify) <b>Burial &amp; Transit</b>		23b. DATE THEREOF <b>12-18-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Somerset Hills Cem.</b>	23d. LOCATION (City or Town) <b>Basking Ridge, N. J.</b>		(County) (State)			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 22 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Rob Roy MacGregor</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

17433

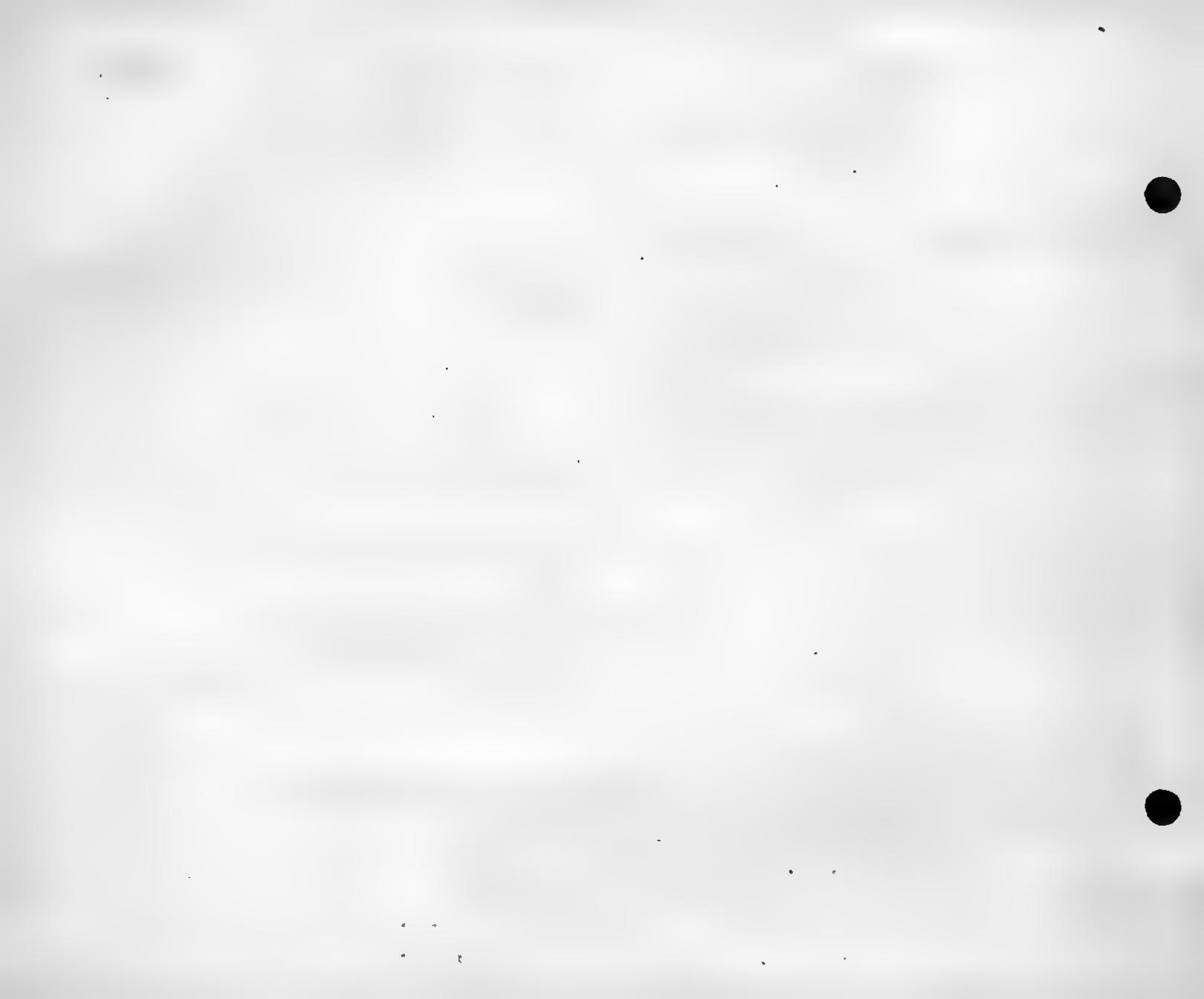
## CERTIFICATE OF DEATH

17425

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
<i>MONTGOMERY</i> MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town)		c. LENGTH OF STAY IN 16 <i>KENSINGTON</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURA and give nearest town) <i>CHEVY CHASE</i>	
KENSINGTON GARDENS SANITARIUM		d. STREET ADDRESS <i>3621 Raymond St.</i>	
3. NAME OF DECEASED (Type or print)		First <i>KATE</i>	Middle <i>B</i>
3. SEX <i>FEMALE</i>		4. DATE OF DEATH Month <i>December</i>	Day Year <i>- 30 1966</i>
5. COLOR OR RACE <i>white</i>		6. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
7. DATE OF BIRTH <i>February 15, 1875</i>		8. AGE (in years last birthday) <i>91 yrs</i>	9. IF UNDER 1 YEAR Months <i>10</i>
10a. USA. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Richmond, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Joseph V. Bickford</i>		14. MOTHER'S MAIDEN NAME <i>SARAH Haupin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>NO</i>		16. SOCIAL SECURITY NO <i>577-05-0515</i>	
17. INFORMANT <i>Mrs Winifred Hanson, Chevy Chase, Md.</i>		Address <i>3621 - Raymond St.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33IX</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<i>generalized arteriosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>A.S. peripheral vasc insufficiency</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>5-31-1964, to 12-30-1966, that (I) (we) last saw the deceased alive on 12-27-1966, and that death occurred on 12-24-1966 PM, from causes and on the date stated above.</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Lorton, Virginia</i>
20f. (City or Town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>12-27-1966</i> , and that death occurred on <i>12-24-1966</i> PM, from causes and on the date stated above.	
22a. SIGNATURE <i>R. L. Sengstack M.D.</i>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>12-30-66</i>
22c. PHYSICIAN'S NAME (Type) <i>G. L. Sengstack</i>		22d. ADDRESS <i>9241 Columbia Blvd. Silver Spring, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-1-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Pohick Church Cem.</i>
23d. LOCATION (City or Town) (County) (State)		23e. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Robert J. Humphrey Jr.</i>		25a. ADDRESS <i>Bethesda, Md.</i>	25b. REC'D BY REGISTRAR DATE JAN 5 1967
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or offending physician director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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## CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and the event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>2 3/4 lbs.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) d. STATE <u>Maryland</u> e. COUNTY <u>Montgomery</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Samaritan + Hospital</u>		d. STREET ADDRESS <u>8209 Roanoke Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard Paul Meyer</u>		First	Middle	Lost	4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1966</u>
S SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>4-14-17</u>	9. AGE (in years lost birthday) <u>49 yrs</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. IF UNDER 24 HRS
10a. JS/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab driver</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Richard Meyer</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Jane Funkhauser</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Arteriosclerotic Heart Disease</u>		DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>DEC 11 1966</u> to <u>DEC 20 1966</u> , that (I) (we) last saw the deceased alive on <u>DEC 20 1966</u> , and that death occurred at <u>682 M</u> , from causes and on the date stated above					
22a. SIGNATURE <u>Albert H. Grollman</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Dec. 21 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN</u>		22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/24/1966</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>St. Lincoln</u>	
24. FUNERAL DIRECTOR <u>Arthur W. Kettler</u>		ADDRESS <u>251 Carroll Street, N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 15 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or ongoing any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>								17427				
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before adm ssion) a. STATE MARYLAND								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ADELPHI</b>		d. STREET ADDRESS <b>1820 METZEROTT ROAD</b>		e. S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2714 WASHINGTON AVENUE</b>												
3. NAME OF DECEASED (Type or print) <b>JENNIE</b>		First	Middle	Lost	4. DATE OF DEATH <b>MEYERS</b>	Month <b>12</b>	Day <b>24</b>	Year <b>1966</b>				
S SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>4-15-88</b>	9. AGE (in years last birthday) <b>78 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>RUSSIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>SAMUEL TAUBE</b>					14. MOTHER'S MAIDEN NAME <b>BETTY ---</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT DAUGHTER			Address <b>MRS. ADELINE KOENICK-2714 WASH. AVE.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>155.1</b>					Cachexia					INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Carcinoma (Adeno) of Gall Bladder</b>					DUE TO (b)	Carcinoma (Adeno) of Gall Bladder					E mos.	
					DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>3A M.</b>		(County) <b>FALLS CHURCH</b>		(State) <b>VA.</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>55</b> , to <b>12/24, 1966</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>12/21 1966</b> , and that death occurred at <b>3A M.</b> from causes and on the date stated above.												
22a. SIGNATURE <i>G. Leonard Gold</i>												
22c. PHYSICIAN'S NAME (Type) <b>G. LEONARD GOLD, M.D.</b>		22d. ADDRESS <b>8641 COLESVILLE RD. SIL. SPG. MD.</b>										
23a. BURIAL, CREMATION, <b>BURIAL</b>		23b. DATE THEREOF <b>12-27-66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>KING DAVID MEMORIAL GARDEN</b>		23d. LOCATION (City or Town) <b>FALLS CHURCH</b>		(County) <b>VA.</b>		(State)		
24. FUNERAL DIRECTOR <b>B. DANZANSKY &amp; SONS</b>		ADDRESS <b>WASHINGTON, D.C.</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

17428

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>KENSINGTON, MD. 151</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>HOLY CROSS HOSPITAL</i>		d. STREET ADDRESS <i>4511 WESTBROOK LANE</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print!) <i>WALTER</i>	First <i>m.</i>	Middle <i>MICHAEL</i>	Last <i>Dec. 7 1966</i>
4. DATE OF DEATH <i>4/30/86</i>	Month <i>Dec.</i>	Day <i>7</i>	Year <i>1966</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>4/30/86</i>
9. AGE (In years last b'day) <i>80 yrs</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>- - - - -</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Retired Clergyman</i>	11. BIRTHPLACE (County & State, or foreign country) <i>MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>MARION S. MICHAEL</i>		
14. MOTHER'S MAIDEN NAME <i>ALICE COPELAND</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		
16. SOCIAL SECURITY NO <i>212-36-2370</i>	17. INFORMANT <i>KATHRYNE J. MICHAEL-SEE ITEM #2</i>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease manifest by:</i> DUE TO 1) Acute antero septal myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2) Left ventricular aneurysm (c) 3) Coronary atherosclerosis with thrombosis			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>(City or town) (County) (State)</i>
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <i>Dec 7 1966</i> , and that death occurred at <i>11:50 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Graham W. Danis</i>		22b. DATE SIGNED <i>12-8-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Graham W. Danis</i>		22d. ADDRESS <i>1106 SPRINGS ST. S.S. MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE THEREOF <i>12-10-1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cemetery</i>	23d. LOCATION (City or Town) <i>Frederick, Md.</i>
24. FUNERAL DIRECTOR <i>Joseph Gavler's Sons, Inc.</i>		ADDRESS <i>5130 Wisconsin Ave. N.W. Wash. DC.</i>	25a. REC'D. BY REGISTRAR <i>DEC 14 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 Film 12/22/66 mh

17437

Item 12 Film G304 12/22/66 mh

## CERTIFICATE OF DEATH

17429

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb --		c. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		d. STREET ADDRESS <b>3219 Pauline Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3219 Pauline Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Stanislaw</b>		First	Middle	Lost	4. DATE OF DEATH Dec. 13, 1966	Month	Day Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-18-1901</b>	9. AGE (In years last birthday) <b>65 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Government</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Politics</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>-Unknown</b>	
13. FATHER'S NAME <b>Stanislaw Mikolajczyk</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Parysik</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I &amp; WW II 578-46-6853</b>		17. INFORMANT <b>3219 Pauline Dr. Chevy Chase, Md</b>		Address <b>Marion M. Mikolajczyk</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Coronary Thrombosis</b>		DUE TO (b) <b>Coronary Artery Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>			
DUE TO (c) <b>Arteriosclerosis</b>						<b>84rs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>		<b>Diabetes Mellitus</b>		<b>Cerebral Thrombosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Injury occurred while at work</b>		20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> o'twork <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20e. (City or town) (County) (State)</b>	
20f. (City or town) <b>19</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>July 5, 1958</b> to <b>Dec 13, 1966</b> that (I) (we) last saw the deceased alive on <b>Dec 8, 1966</b> , and that death occurred at <b>8A.M.</b> from causes and on the date stated above.							
22o. SIGNATURE <b>Theodore J. Abernethy</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-13-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Theodore J. Abernethy</b>		22d. ADDRESS <b>916-19th St. N.W. Wash. D.C.</b>					
23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-17-1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Joseph Jawler's Sons, Inc.</b>		ADDRESS <b>5130 Wisconsin Ave. N.W. Wash. DC</b>		25o. REC'D BY REGISTRAR <b>DEC 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

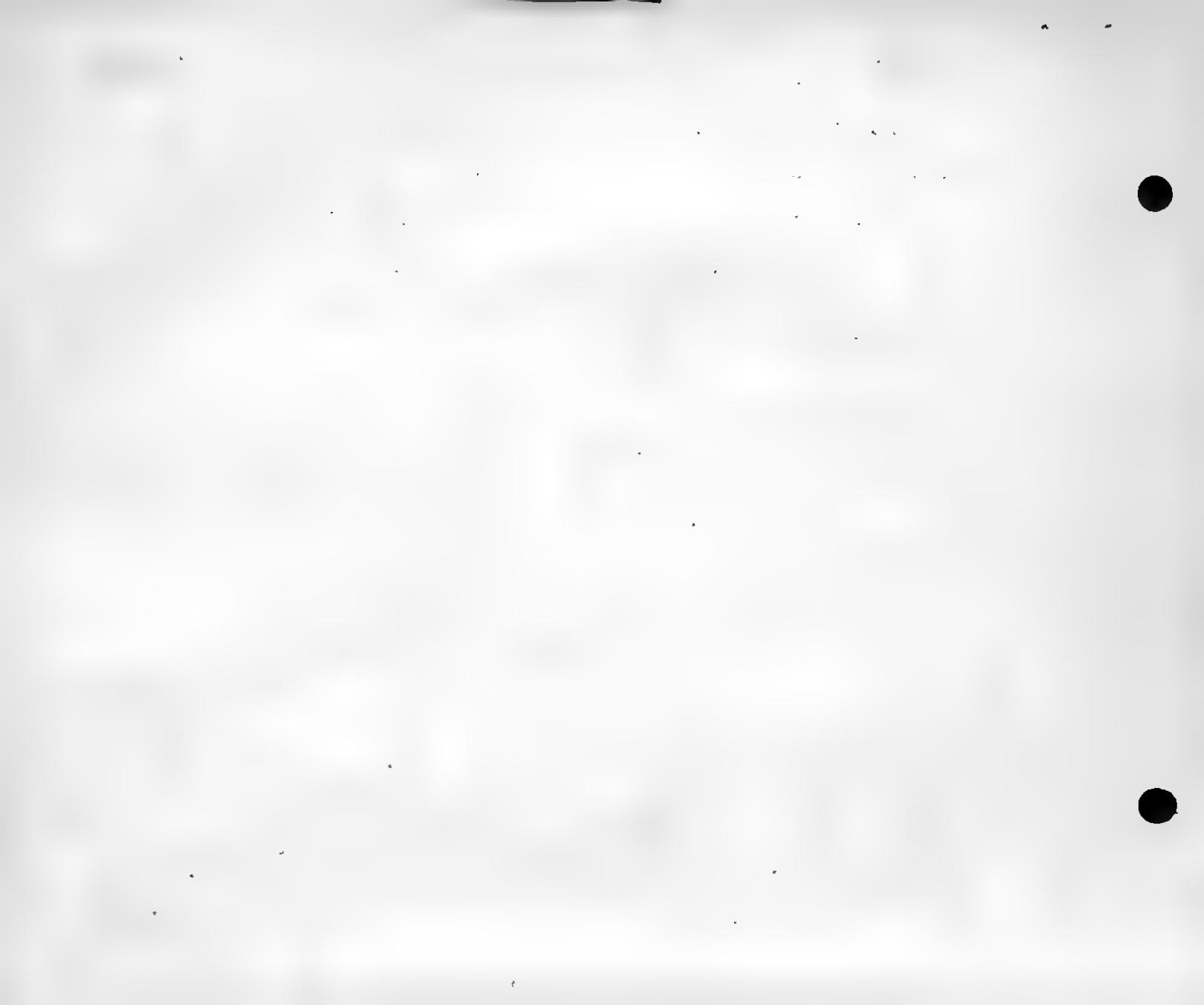
17438

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17430

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rand Germantown</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN fb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Germantown Route</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Rt #118</i>		d. STREET ADDRESS <i>Rt 118</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Clarendell</i>	Middle <i>Warden</i>	Last <i>Miller</i>
4. DATE OF DEATH	Month <i>Dec</i>	Day <i>11</i>	Year <i>1966</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 6 1916</i>
9. AGE (In years last birthday) yrs <i>52</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Unobtainable</i>	11. BIRTHPLACE (State or foreign country) <i>Ind</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13. FATHER'S NAME <i>Horace Carter</i>	14. MOTHER'S MAIDEN NAME <i>Bessie</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unk, unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>Unobtainable</i>	17. INFORMANT <i>Max P. Miller same item # 2 - Husband</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocarditis</i>		INTERVAL BETWEEN DEATH AND DEATH <i>3 day?</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), (c)		DUE TO	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Unobtainable</i> (County) <i>Unobtainable</i> (State) <i>Unobtainable</i>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		
EXAMINER'S NAME (Type) <i>John G. Ball</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address, street, city, state, zip code, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/15/66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Forest Oak Cemetery</i>	23d. LOCATION (City or Town) <i>Gaithersburg, Montg. Md.</i> (Co.) (State)
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>	ADDRESS <i>1331 Rock Pike Rockville, Maryland</i>	25a. REC'D BY REGISTRAR DATE <i>DEC 16 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Page 3, and in any event within 72 hours after death, and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
17439			17431								
1. PLACE OF DEATH a. COUNTY			Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			b. STATE			Maryland		
Rockville, Maryland						b. COUNTY			Montgomery		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Rockville, Maryland		
Southlawn Lane, Rockville, Maryland						d. STREET ADDRESS			Southlawn Lane		
3. NAME OF DECEASED (Type or print) EARL			First ROBERT	Middle S.	Last Miller	4. DATE OF DEATH	Month December	Day 5	Year 1966	e. IS RESIDENCE ON A FARM?	
5. SEX Male			6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 13, 1916	9. AGE (in years last birthday) 50 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William R. Miller			14. MOTHER'S MAIDEN NAME Edna M. Kincaid			Address Southlawn Lane			Address Rockville, Maryland		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW II			16. SOCIAL SECURITY NO. 232-12-3850	17. INFORMANT Edward R. Miller			INTERVAL BETWEEN ONSET AND DEATH			INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1			Coronary Insufficiency Acute -								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			DUE TO								
(c)			DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) chronic Alcoholism -											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John G. Ball						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John G. Ball 7936 Old Georgetown						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22. DATE SIGNED 12/5/66		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/8/66			23c. NAME OF CEMETERY OR CREMATORIAL Arlington National			23d. LOCATION (City, town or county) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Maryland			24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DEC 7 1966 Charles Judge								
VR AISM (5) 5M 1/65											



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FOR STATE  
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17440

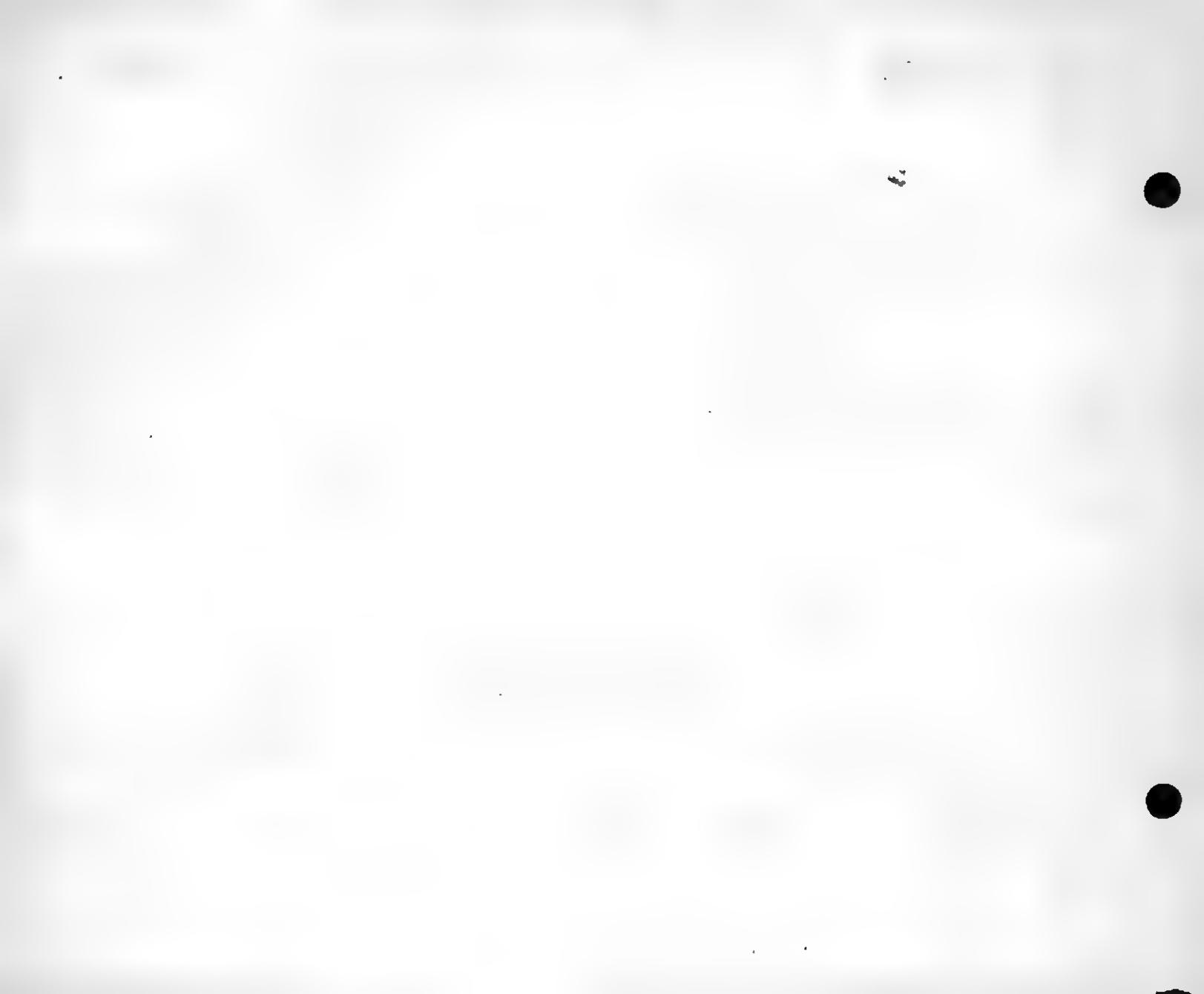
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17432

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'Pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMB Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal. In any event, within 72 hours after death.

1 PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)				
a. COUNTY	Maryland	a. STATE	b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL, and give nearest town)	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	d. STREET ADDRESS			
Montgomery		Gaithersburg	Ken Mar Farm-Turkey Foot Rd.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?				
Ken Mar Farm-Turkey Foot Rd.		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last			
Kenneth	D		Miller			
4. DATE OF DEATH	Month	Day	Year			
Dec.	30	1966				
5. SEX	6. COLOR OR RACE	7. MARRIED	8. DATE OF BIRTH	9. AGE (In years lost birthday)	F. UNDER 1 YEAR	I. F. UNDER 24 HRS
M.	W.	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	Mar 24-1910 56	67 yrs	Months 6 Days 2 Hours 0 Min. 0	
10a. USUAL DECLARATION (Give kind of work done during month of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
city of law		a		Springfield, Inc.		U.S.A
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Herbert Miller		Lura Dobson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address
						Kathleen Miller, Gaithersburg Md
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		ASPHYXIA - Smoke & Heat Inhalation		INTERVAL BETWEEN ONSET AND DEATH
916.c		DUE TO				1pm
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b)		DUE TO		House Fire -		
stated		(c)				
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED?
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		House caught on fire -				
20c. TIME OF INJURY Month, Day Year Hour a.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Gaithersburg Montgomery Md.
3:00 pm 12/30/1966				Home		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John S. Ball MD				
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)						
23a. BURIAL, CREMATION REMOVAL (SPECIFY)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.
Burial		1-3-67		Gate of Heaven		
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Ernest C. Gartner		Md		DATE JAN 5 1967		Charles Judge



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17441

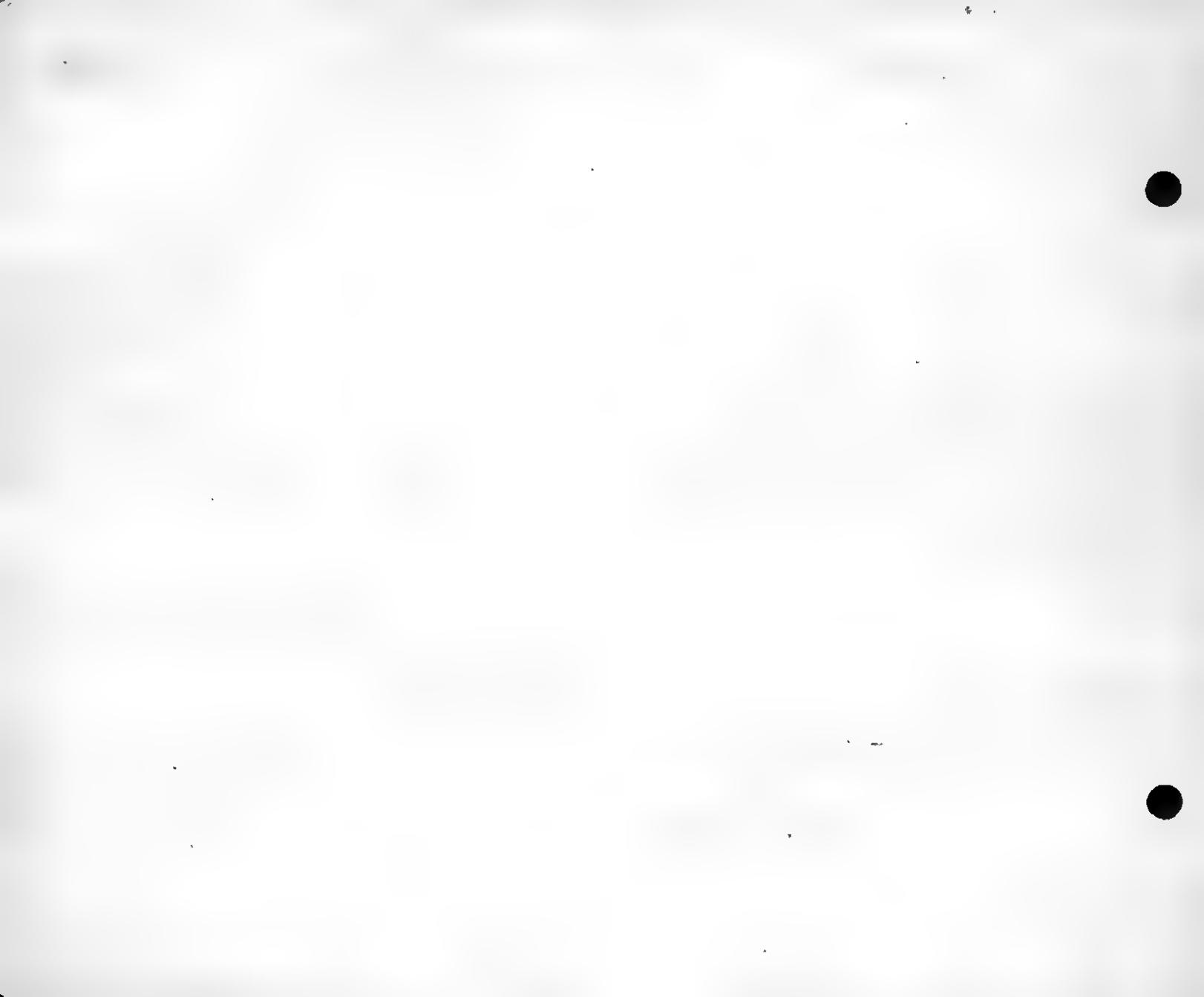
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17438

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>1 hr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>Rural Gaithersburg</u>	
3. NAME OF DECEASED (Type or print) <u>MARTIN</u> First <u>BROSS</u> Middle <u>MILLER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1966</u>	
S SEX <u>M-</u>	6. COLOR OR RACE <u>W-</u>	7. MARRIED <input type="checkbox"/> NEVER MARR ED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>Apr 7-1935</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>n</u>	
11. BIRTHPLACE (State or foreign country) <u>Gaithersburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kenneth D. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Muller McLaughlin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Kathleen Miller-Gaithersburg</u>		Address <u>1000 Galtwood Lane</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>916.0</u> DUE TO <u>ASPHYXIA-Smoke+Heat Inhalation.</u>		INTERVAL BETWEEN DEATH AND DEATH <u>2 hr.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>House-Fire -</u> (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) <u>Home-caught on fire -</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>3:00 pm 12/30 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Gaithersburg Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Bell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>12/30/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-5-67</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>Gate of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Veterans Bridge, Gaithersburg, Md.</u>	
24. FUNERAL DIRECTOR Ernest C. Gartner ADDRESS <u>Ernest C. Gartner Gaithersburg</u>		25a. REC'D BY REGISTRAR DATE JAN 5 1967	
25b. REGISTRAR'S SIGNAT. RE <u>Jane, Judge</u>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

17442

17434

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Items 1 through 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased lived if institution Res dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Gaithersburg</b>		c LENGTH OF STAY IN lb	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ken Mar Farm, Turkey Foot Rd.</b>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R Gaithersburg</b>	
3 NAME OF DECEASED (Type or print) <b>Mary Ann Miller</b>		4 DATE OF DEATH Month <b>Dec</b> Day <b>30</b> Year <b>1966</b>	
S SEX <b>f</b>	6 COLOR OR RACE <b>w.</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec 9-1913</b> (33) last b'day <b>63</b> yrs
10a. USU OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b K ND OF BUSINESS OR INDUSTRY <b>"</b>	
11 BIRTHPLACE (State or foreign country) <b>Detroit Mich</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Marie F. M. Langblair</b>		14 MOTHER'S MAIDEN NAME <b>Hethayss Creek</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <b>No</b>		16 SOC. SECURITY NO <b>INFORMANT</b> <b>Kathleen Miller, Gaithersburg Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxia - Smoke + Heat Inhalation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) <b>House Fire</b>	
		DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <b>Home - Caught on fire -</b>	
20c. TIME OF INJURY Month, Day, Year Hour am <b>3:00 pm 12/30 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street off ce bldg, etc.) <b>Home -</b>	
20f. (City or town) <b>Bethesda</b> (County) <b>Montgomery</b> (State) <b>Md</b>		20g. (City or town) <b>Bethesda</b> (County) <b>Montgomery</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John S. Ball</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		22. DATE SIGNED <b>12/30/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-3-67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Montgomery, Md</b>	
24. FUNERAL DIRECTOR <b>Ernest E. Gartner</b>		ADDRESS <b>3rd St &amp; G St, Gaithersburg, Md</b>	
25a. REC'D BY REG STAR <b>JAN 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Judge</b>	
DATE			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17435

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>59 minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria 22314</b>		d. STREET ADDRESS <b>905 South Washington Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Paul</b>	Middle <b>James</b>	Last <b>Miller</b>	4. DATE OF DEATH <b>December 22 1966</b>	Month <b>December</b>	Day <b>22</b>	Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>16 August 1966</b>	9. AGE (In years last birthday) yrs <b>4</b>	IF UNDER 1 YEAR <b>Months 4</b>	IF UNDER 24 HRS <b>Days 7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arnold W. Miller</b>				14. MOTHER'S MAIDEN NAME <b>Effie Roach</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record, Address The Clinical Center, Bethesda, Md. 20014</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypocalcemic tetany</b> INTERVAL BETWEEN ONSET AND DEATH <b>492 X 2 hours</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Massive Aspiration of gastric contents</b> 1 hour							
DUE TO (c) <b>probable Bilateral, massive pneumonitis and / sepsis</b> 1 day							
DUE TO							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>22 December 1966</b> , to <b>22 December 1966</b> that <b>XX</b> (we) last saw the deceased alive on <b>22 December 1966</b> , and that death occurred at <b>11:59 AM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>Ronald Kallen</b>		22b. DATE SIGNED <b>22 Dec. 1966</b>					
22c. PHYSICIAN'S NAME (Type) <b>Ronald Kallen, MD</b>		22d. ADDRESS National Institutes of Health, <b>The Clinical Center, Bethesda, Md. 20014</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>24 Dec. 66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Beahms Chapel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Page Co., Virginia</b>	
24. FUNERAL DIRECTOR <b>B. Eagle Mountcastle</b>		ADDRESS <b>Cunningham Funeral Home, Alexandria Virginia</b>		25a. REC'D BY REGISTRAR <b>UFC 37 1966</b>		25b. REGISTRAR'S SIGNATURE <b>"new page"</b>	



MARYLAND STATE  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON

**CERTIFICATE OF DEATH**

**17446**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
<i>Arlington, Virginia</i> <i>Maryland</i>		<i>Virginia</i> <b>b. COUNTY</b> <b>17436</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Washington, D.C.</i> <i>Rural 340 days</i>		<i>Washington</i> <b>83-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>The Suburban</i>		d. STREET ADDRESS <i>1200 - S. Courtland St.</i>	
3 NAME OF DECEASED (Type or print)	First <i>Stan</i>	Middle <i>Moreno</i>	Last <b>Dec. 20 1966</b>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>12-16-10</i> <b>56</b> 9. AGE (In years last birthday) yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Broker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>	11 BIRTHPLACE (Country & State, or foreign country) <i>Columbia, S.A.</i> <b>Colombia</b>	
13. FATHER'S NAME <i>Unknown</i>	14. MOTHER'S MAIDEN NAME <i>Rita Gutierrez</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <b>No</b>	16. SOCIAL SECURITY NO. <i>Unknown</i>	17. INFORMANT <i>Christina L. Hernandez</i>	Address <i>1102-A 1/2 House St./Smithfield</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>Respiratory Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <b>15 MIN</b>	
IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>		DUE TO <b>3 DAYS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { <i>CERERAL THROMBOSIS</i>		DUE TO <b>2 YRS</b>	
(b) <i>GENERALIZED ARTERIOSCLEROSIS</i>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town) <b>12/17/66</b>	(County) <b>19</b> (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/17/66</b> , 19 <b>66</b> , to <b>12/20</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/20</b> , 19 <b>66</b> , and that death occurred at <b>915P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Thomas F. O'Connor</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/20/66</b>
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. O'CONNOR</b>		22d. ADDRESS <b>8219 WISCONSIN AVE, BETHESDA, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/27/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Columbia Gardens Cemetery</i>
			23d. LOCATION (City or Town) <b>Arlington, Virginia</b> (County) <b>Virginia</b> (State)
24. FUNERAL DIRECTOR <i>Murphy Funeral Home, Arlington, Virginia</i>		25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>	25b. REGISTRAR'S SIGNATURE <i>John Murphy</i>



FOR STATE  
HEALTH DEPT.

17445

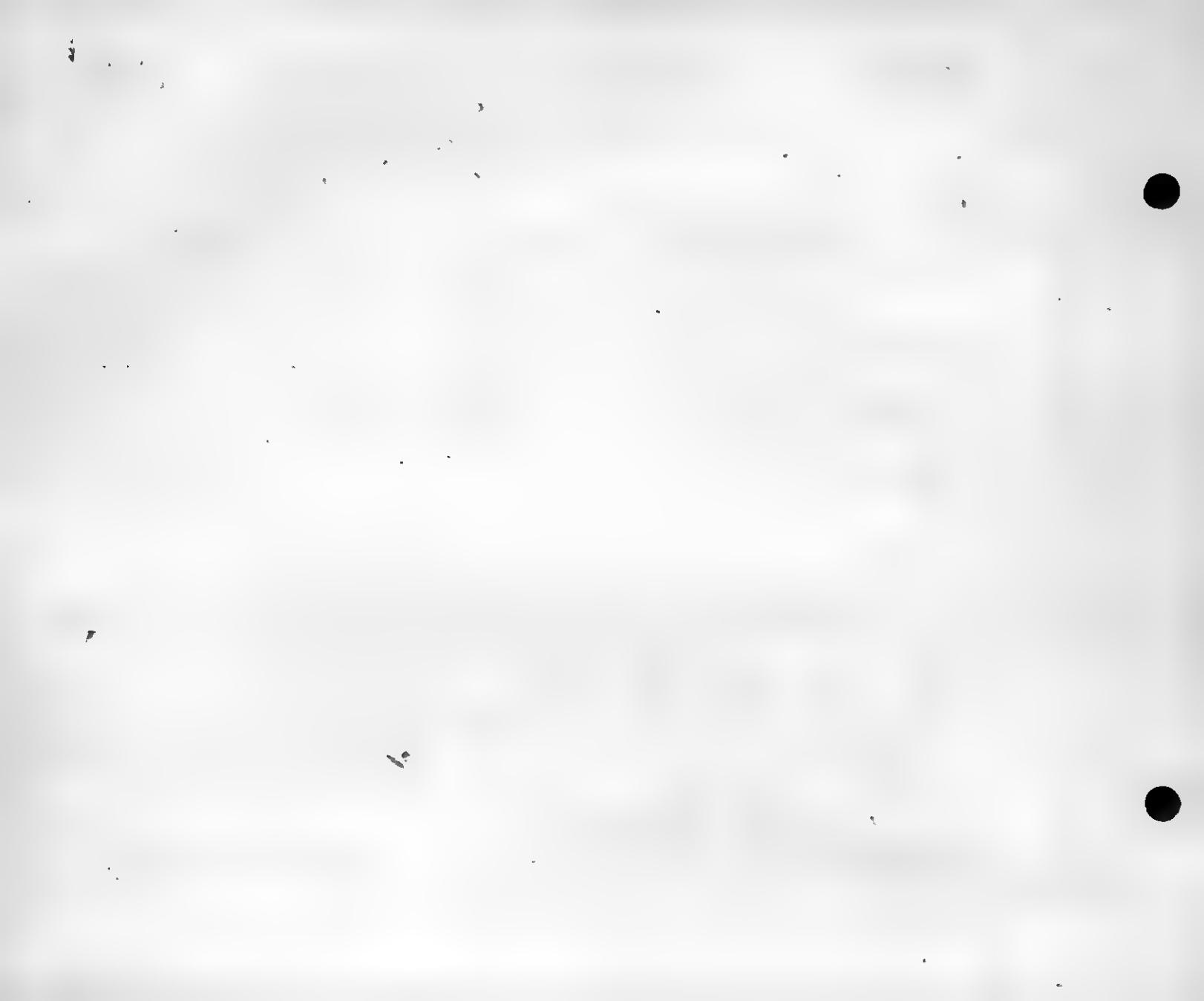
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17437

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. See pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Montgomery</b>		2 USUAL RESIDENCE (Where deceased resided if institution Residence before admission) a STATE <b>Maryland</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c LENGTH OF STAY IN 1b <b>35 years</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9834 Capital View Avenue</b>		e STREET ADDRESS <b>9834 Capitol View Ave.</b>	
3 NAME OF DECEASED (Type or print) <b>Helice Tracy Morgan</b>		4 DATE OF DEATH Month Day Year <b>12 - 27 1966</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8 OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9 B DATE OF BIRTH <b>March 18, 1889</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		9 AGE (In years lost birthday) <b>77 yrs.</b>	
11 BIRTHPLACE (State or foreign country) <b>New Orleans, La.</b>		12 CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Washington James Tracy</b>		14 MOTHER'S MAIDEN NAME <b>Cora Mary Blee</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>		16 SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>Miss Cora M. Tracy</b>		18 ADDRESS <b>9834 Capitol View Ave. Silver Spring, Md.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: NAMED AS CAUSE (a) <b>Acute bronchopneumonia;</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		20. INTERVAL BETWEEN ONSET AND DEATH	
(b) <b>Gangrenous Cholecystitis and</b> DUE TO			
(c) <b>Acute peritonitis</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour am pm. <b>19</b>		20d INJURY OCCURRED Where <input type="checkbox"/> Not Where at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Helice K. Tracy</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAGAN, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, City, Town, or County) <b>Cleveland, Ohio</b>	
22. DATE SIGNED <b>12/27/1966</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Trans-burial</b>		23b DATE THEREOF <b>Dec. 30, 1966</b>	
23c NAME OF CEMETERY OR CREMATORIAL <b>Lakeview Cemetery</b>		23d LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>John B. Thomas Warren E. Humphrey, Inc.</b>		25a ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>	
25b REC'D BY REGISTRAR DATE JAN 3 1967		25b REGISTRAR'S SIGNATURE <b>Charles J. ...</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17446

## CERTIFICATE OF DEATH

17436

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>9304 OGDEN APT. 1</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1D <b>1/2 hr.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	LAST First <b>MUNDY</b>	MIDDLE <b>LAWRENCE</b>	4. DATE OF DEATH <b>12/22/66</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/16/45</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAIL CARRIER U.S. POST OFFICE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. POST OFFICE</b>	11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James J. Mundy</b>	14. MOTHER'S MAIDEN NAME <b>Florence A. Robinson</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				
16. SOCIAL SECURITY NO. <b>217424688</b>		17. INFORMANT <b>Florence A. Mundy Lantam Md-</b>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac tamponade due to hemopericardium</b>						
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>due to ruptured aortic aneurysm</b> (c)						
DUE TO DUE TO DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Congenital heart disease 1. interventricular septal defect 2. Bicuspid aortic valve</b>						
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>East</b>	20f. (City or town) <b>Baltimore</b>	(County) <b>Baltimore</b>	(State) <b>Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 19, 1952</b> , to <b>Dec. 22, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 19, 1966</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
22. SIGNATURE <b>Dr. Weintraub</b>				22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Dr. Weintraub</b>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>Greenbelt, Md.</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec 24, 1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Forest Glen Cemetery</b>	23d. LOCATION (City, town or county) <b>Cotman Manor 1220 Lee Rd</b>
24. FUNERAL DIRECTOR <b>F. Weintraub</b>	ADDRESS <b>1500 Forest Glen Rd. SS</b>	25a. REC'D BY REGISTRAR <b>DEC 3 1966</b>	25b. REGISTRAR'S SIGNATURE
DATE <b>1966</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR After this certificate is signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17441

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <i>District of Columbia</i>	b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Md.</i>	c. LENGTH OF STAY IN 1B <i>6 months</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	d. STREET ADDRESS <i>3548 Quebec St. N.W.</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Athena Woodland Nursing Home</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>MARIANE</i>	First MIDDLE Last Munk-Pedersen	4. DATE OF DEATH Month 12 Day 16 Year 1966				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-26-1890</i>	9. AGE (in years last birthday) <i>75 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Denmark</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Niels Margard</i>	14. MOTHER'S MAIDEN NAME <i>Maren Sorensen</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>	16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>Mrs. Russell Nielsen - 3610-35th St. N.W., Wash.</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Chronic Lymphatic Leukemia</i> DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>3 years</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized &amp; coronary arterio sclerosis</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>	
21. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1966</i> to <i>Dec. 16, 1966</i> , that (I) (we) last saw the deceased alive on <i>Nov 13 1966</i> , and that death occurred at <i>637</i> M, from the causes and on the date stated above.	22a. SIGNATURE <i>Richard Kaufman</i>	22b. DATE SIGNED <i>Dec. 16, 1966</i>				
22c. PHYSICIAN'S NAME (Type) <i>RICHARD KAUFMAN MD</i>	22d. ADDRESS <i>712 EYE ST NW WASH. D.C.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>12/19/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>CEDAR HILL 3072 M ST. NW WASH. D.C.</i>	23d. LOCATION (City, town or county) <i>SUITLAND MD.</i>	(State) <i></i>		
24. FUNERAL DIRECTOR <i>W.W. CHAMBERS CO. INC.</i>	25a. REC'D BY REGISTRAR <i>DATE 12-19-66</i>	25b. REGISTRAR'S SIGNATURE <i>W.W. CHAMBERS CO. INC.</i>				



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4** may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, then ~~please~~ remove carbon papers. Pages 1 and 2 director, page 3 should be detached for use as the burial-transit permit. Then ~~please~~ remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17448

## CERTIFICATE OF DEATH

17434

1. PLACE OF DEATH  
a. COUNTY

Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring 28 days

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Holy Cross Hospital

3. NAME OF  
DECEASED  
(Type or print)

First

Middle Myers

Last

May A

4. DATE  
OF  
DEATH

Month

Day

Year

12

30

1966

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

## 8. DATE OF BIRTH

5-23-96

9. AGE (In years  
last birthday)

70 yrs.

10. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Retired (A.P. Power Co.)

10b. KIND OF BUSINESS OR  
INDUSTRY

Electric Power

## 11. BIRTHPLACE (County &amp; State, or foreign country)

Indiana

12. CITIZEN OF WHAT  
COUNTRY?

USA

## 13. FATHER'S NAME

Samuel Myers

## 14. MOTHER'S MAIDEN NAME

Edith ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

UNKNOWN

## 16. SOCIAL SECURITY NO.

535-01-5655  
XXXXXX

## 17. INFORMANT

Wilfred Myers

## 18. ADDRESS

7307-Riggs Road  
Hyattsville, Maryland

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

CELEBRAL EMBOLISM

INTERVAL BETWEEN  
ONSET AND DEATH

1 day

Conditions, If any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

## DUE TO

(b) ARTERIOSCLEROTIC HEART DISEASE, ATRIAL FIBRILL  
-ATION

## YEARS

## DUE TO

(c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. While at work  Not While at work   
p.m. 19

## 20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

21. I certify that (I) (this hospital) attended the deceased from 12/17, 1966, to 12/30, 1966, that (I) (we) last  
saw the deceased alive on 12/30 1966, and that death occurred at 8P M, from the causes and on the date stated above.

## 22a. SIGNATURE

Richard H. Pollen

## 22b. DATE SIGNED

12/31/66

22c. PHYSICIAN'S  
NAME (Type)

RICHARD H. POLLIN

M.D. ATTENDING  
PHYS. MED.  
DIRECTOR  STAFF  
PHYS. 22d. ADDRESS  
10400 CONNECTICUT Ave, KENSINGTON MD

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

## 23b. DATE THEREOF

## 23c. NAME OF CEMETERY OR CREMATORIAL

## 23d. LOCATION (City, town or county) (State)

BURIAL 1/3/1967 SUNSET MEMORIAL PARK SOUTH CHARLESTON 1st VA

## 24c. FUNERAL DIRECTOR

## ADDRESS 8434 Ga. Ave

## 25b. REGISTRAR'S SIGNATURE

## Glen Carter C. Glen Carter

## REC'D BY REGISTRAR

## WARNER PHUM PHREY SILVER SPRING

## DATE JAN 6 1967

MARYLAND

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17449

## CERTIFICATE OF DEATH

17442

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN lb <i>Suburban Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>402 Green Ave.</i>	
e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>First: Dore "a" Nahoum Middle: Nahoum Last:</i>		4. DATE OF DEATH <i>Dec. 27 1966</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <i>Dec. 27, 1966</i>	
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henri Nahoum</i>		14. MOTHER'S MAIDEN NAME <i>Esther Quenac</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. <i>WONS Father</i>	
17. INFORMANT <i>imaturity</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>twins pregnancy + hydramnion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from ..... 19..... to ..... 19....., that (I) (we) last saw the deceased alive on ..... 19....., and that death occurred at ..... AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Anna M. L. Van Rooy</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>ANNA M. L. VAN ROOY</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <i>3000 Conn Ave Wash D.C.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>12-29-66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Holmesdale Nat'l Cem</i>		23d. LOCATION (City, town or county) <i>Arlington</i> (State) <i>Vir</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Goldsberg Funeral Home</i>		ADDRESS <i>4217-9th St. N.W.</i>	
25a. REC'D BY REG. STRR. DATE <i>DEC 30 1966</i>		25b. REGISTRAR'S SIGNATURE <i>John's Judge</i>	
VR A15 (4) 15M 9/60			



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

17450      17443

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>Maryland</i>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN lb <i>Suburbay Hospital</i>	b. COUNTY <i>Montgomery</i>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Sid B Nahoum</i>	First Middle Last	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring, Md.</i>
3. NAME OF DECEASED (Type or print) <i>Sid B Nahoum</i>	4. DATE OF DEATH Month Day Year <i>Dec 27 1966</i>	d. STREET ADDRESS <i>402 Glebe Ave</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. B. DATE OF BIRTH <i>Dec 27, 1966</i>	6. IF UNDER 1 YEAR last birthday Months Days Hours Min. <i>yrs. 5 14 5 14</i>
9. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE County & State, or foreign country <i>MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Henri Nahoum</i>	14. MOTHER'S MAIDEN NAME <i>Esther Dueñas</i>	Address <i>402 Glebe Ave, S.S., Md.</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Father</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>Immaturity</i>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>73.5</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Twins pregnancy - hydramnios</i>		
DUE TO (c) <i>Immaturity</i>		
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from ..... to ..... 19....., that (I) (we) last saw the deceased alive on ..... 19....., and that death occurred at ..... 7:00 AM, from the causes and on the date stated above.		
22a. SIGNATURE <i>Anna M.L. Van Rooy</i>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <i>Anna M.L. Van Rooy</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <i>Burial</i> 12-29-66		23c. NAME OF CEMETERY OR OREMATORIY <i>Arlington Nat'l Cem.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Holberg Funeral Home</i>		23d. LOCATION (City, town or county) (State) <i>Arlington Va</i>
ADDRESS <i>4217-9th St. N.W.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 30 1966</i>
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17451

## CERTIFICATE OF DEATH

17444

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Montgomery MARYLAND		a. STATE Pennsylvania	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY	
c. LENGTH OF STAY IN 1b 40 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walnut Bottom	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland 20014		d. STREET ADDRESS Box 42	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Peter Middle Ellsworth Last Naugle		4. DATE OF DEATH December 13 1966	
5. SEX Male White 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 19 October 1946		9. AGE (In years last birthday) 20 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
9. AGE (In years last birthday) 20 yrs. IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ambrose E. Naugle		14. MOTHER'S MAIDEN NAME Mary Ewan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 206-34-8351 17. INFORMANT The Medical Record, Address The Clinical Center, Bethesda, Md. 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas Septicemia		2 Weeks	
204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Subarachnoid hemorrhage	
		DUE TO (c) Acute Leukemia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		14 Hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3 November, 1966, to 13 December 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 13 December 1966, and that death occurred at 9:00 AM, from the causes and on the date stated above.		22b. DATE SIGNED 12/13/66	
22a. SIGNATURE J.L. Spivak		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 12/13/66	
22c. PHYSICIAN'S NAME (Type) Jerry L. Spivak, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014	
23a. BURIAL, CREMATION, REMOVAL Removal Serial 12-16-66		23c. NAME OF CEMETERY OR CREMATORIUM Spring Hill Cemetery Shippensburg, Pa.	
24. FUNERAL DIRECTOR Robert A. Pumphrey, 7557 Wisc. Ave. Bethesda, Md.		23d. LOCATION (City, town or county) (State) ADDRESS DEC 19 1966 25a. REC'D BY REGISTRAR DEC 19 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17452

17445

1. PLACE OF DEATH  
a. COUNTY

MONTGOMERY MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Takoma Park**

LENGTH OF STAY IN TB  
**7 days**

c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  
**Washington San. & Hospital**

3. NAME OF  
DECEASED  
(Type or print)

First Middle  
**Carl Aubry NELSON.**

Last  
**NELSON**

4. DATE  
OF  
DEATH

**12**

Month  
**15** Day  
**1966**

5. SEX  
**M**

6. COLOR OR RACE  
**W**

7. MARRIED  
 NEVER MARRIED  
 WIDOWED  
 DIVORCED

8. DATE OF BIRTH  
**4-22-07**

9. AGE (In years  
last birthday)  
**59** yrs.

10. IF UNDER 1 YEAR  
Months  
**0** Days  
**0** Hours  
**0** Min.  
IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)  
**Ret. Auto Dealer**

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (County & State or foreign country)  
**Va.**

12. CITIZEN OF WHAT  
COUNTRY?  
**U.S.**

13. FATHER'S NAME  
**Charles H. Nelson**

14. MOTHER'S MAIDEN NAME  
**Mayde Trainum**

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) If yes give war or dates of service)  
**No**

16. SOCIAL SECURITY NO.

17. INFORMANT  
**Hospital chart.**

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

-PART I- DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Conditions, if any, which gave  
rise to immediate cause (a),  
stating the underlying cause  
lost

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

④ Esophageal Varices = GI Bleeding

INTERVAL BETWEEN  
ONSET AND DEATH

5-6 days

SEVERAL yrs.

20a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m.

20d. INJURY OCCURRED  
While at work  Not While  
at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

**38**

21. I certify that (I) (this hospital) attended the deceased from **12-8-**, 19**66**, to **11-27-1966**, that (I) (we) last  
saw the deceased alive on **19**, and that death occurred at **M**, from causes and on the date stated above.

22a. SIGNATURE  


M.D. ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22b. DATE SIGNED  
**Dec 15, 1966**

22c. PHYSICIAN'S  
NAME (Type)

22d. ADDRESS  
**Takoma Park, Md.**

23a. BURIAL, CREMATION,  
REMOVAL (Specify)  
**Burial**

23b. DATE THEREOF  
**Dec 17-1966**

23c. NAME OF CEMETERY OR CREMATORIUM  
**St. Lincoln Cemetery**

23d. LOCATION (City or Town)  
**Elmwood Manor Bro. Co. Md.**

(County) (State)

24. FUNERAL DIRECTOR  
**F. Gascha sons Hyattsville, Md.**

ADDRESS  
**Hyattsville, Md.**

25a. REC'D BY REGISTRAR  
DATE  
**DEC 19 1966**

25b. REGISTRAR'S SIGNATURE  
**Judge**



M

FOR STATE  
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

17453

17446

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. COUNTY	
Silver Spring		1 week		Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?			
2704 Finch St.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Kate Hazel</i>	Middle <i>Anna</i>	4. DATE OF DEATH	Month December Day 24 Year 1966
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday) 68 yrs.
Female		White		November 26, 1898	IF UNDER 1YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ret. Seamstress		Jellett's		Minnesota	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Nels Mallum		Radcliffe Purdy		U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		Mr. Alvin Norquist 2704 Finch St. Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		Address INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Acute Coronary Insufficiency</i>			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<i>Coronary Artery Heart Disease</i>			
DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
19					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Belden Reaps</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/27/1966	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		22c. NAME OF CEMETERY OR CREMATORIAL REMOVAL (Specify) Burial Dec. 28, 1966 Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co., Md.	
22b. BURIAL, CREMATION, [22b. DATE THEREOF REMOVAL (Specify)] Burial Dec. 28, 1966 Fort Lincoln Cemetery		22c. NAME OF CEMETERY OR CREMATORIAL REMOVAL (Specify) Clark E. Wison & Friends 8454 Georgia Ave.		22d. LOCATION (City, town, or county) (State) Prince Georges Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		ADDRESS Silver Spring, Md.		24a. REC'D. BY REGISTRAR DATE JAN 3 1967 24b. REGISTRAR'S SIGNATURE <i>John J. Coughlin</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17454

CERTIFICATE OF DEATH

17447

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner for

1 PLACE OF DEATH a. COUNTY <b>Montgomery, Silver Spring, Maryland</b>			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville, Md.</b>		c LENGTH OF STAY IN lb c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville, Md.</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>			d. STREET ADDRESS <b>11323 Schuylkill Rd.</b>								
3 NAME OF DECEASED (Type or print)		First <b>Olive</b>	Middle <b>D</b>	Last <b>Norris</b>	4. DATE OF DEATH <b>Dec. 17</b>	Month <b>Dec.</b>	Day <b>17</b>	Year <b>1966</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-17</b>	9 AGE (In years lost, birthday) <b>49 yrs.</b>	10. UNDER 1 YEAR Months <input type="checkbox"/>	11. UNDER 24 HRS. Days <input type="checkbox"/>	12. HOURS Hours <input type="checkbox"/>	13. MIN.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>refrig. air cond. mech.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NOL</b>			11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Anson Norris</b>			14. MOTHER'S MAIDEN NAME <b>Maggie Sanderson</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO <b>242-16-4542</b>			17. INFORMANT <b>Mary O. Norris - Item # 2</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>									INTERVAL BETWEEN ONSET AND DEATH		
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { lost. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <b>Durham</b> (County) <b>N. Carolina</b> (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>12/17/66</b> , to <b>12/17/66</b> that (I) (we) last saw the deceased alive on <b>12/17/66</b> , and that death occurred at <b>2 P.M.</b> from causes and on the date stated above.											
22a. SIGNATURE <i>Morris Perry</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>12/17/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Morris Perry</b>			22d. ADDRESS <b>11602 Georgia Avenue S. S. MD</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		23b. DATE THEREOF <b>12/21/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Maplewood</b>			23d. LOCATION (City or Town) <b>Durham</b> (County) <b>N. Carolina</b> (State)				
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.		ADDRESS Rockville, Md.			25a. REC'D BY REGISTRAR Date <b>DEC 22 1966</b>			25b. REGISTRAR'S SIGNATURE <i>Morris Judy</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 11,12 Film 384 12/23/66 mh

17455

## CERTIFICATE OF DEATH

17448

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retorted by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 16 21 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Portsmouth	
d. STREET ADDRESS 22 Helm Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sally Middle Levy Last NORRIS		4. DATE OF DEATH Month December Day 7 Year 1966	
S SEX Female	6 COLOR OR RACE Cauc	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH Apr. 9, 1939
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY N/A	
13. FATHER'S NAME Unknown		11. BIRTHPLACE (County & State or foreign country) Rabat France France Morocco	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO 230 66 6096	
17. INFORMANT Portsmouth		Address Virginia William C. Norris, III, 22 Helm Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  410X Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) open Heart Surgery with mitral valve replacement DUE TO (c) Rheumatic Heart Disease with mitral stenosis and insufficiency	
		INTERVAL BETWEEN ONSET AND DEATH 14t	
		2hrs	
		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (s) (this hospital) attended the deceased from Nov. 16, 1966, to Dec. 7, 1966, that (s) (we) last saw the deceased alive on Dec. 7, 1966, and that death occurred at 130 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Mitchell Mills</i>		22b. DATE SIGNED Dec. 8, 1966	
22c. PHYSICIAN'S NAME (Type) Mitchell Mills, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-9-66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Gomley Chesed Cem.
23d. LOCATION (City or Town) Portsmouth, Virginia		(County) (State)	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR DATE DEC 15 1966	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>



X  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17456

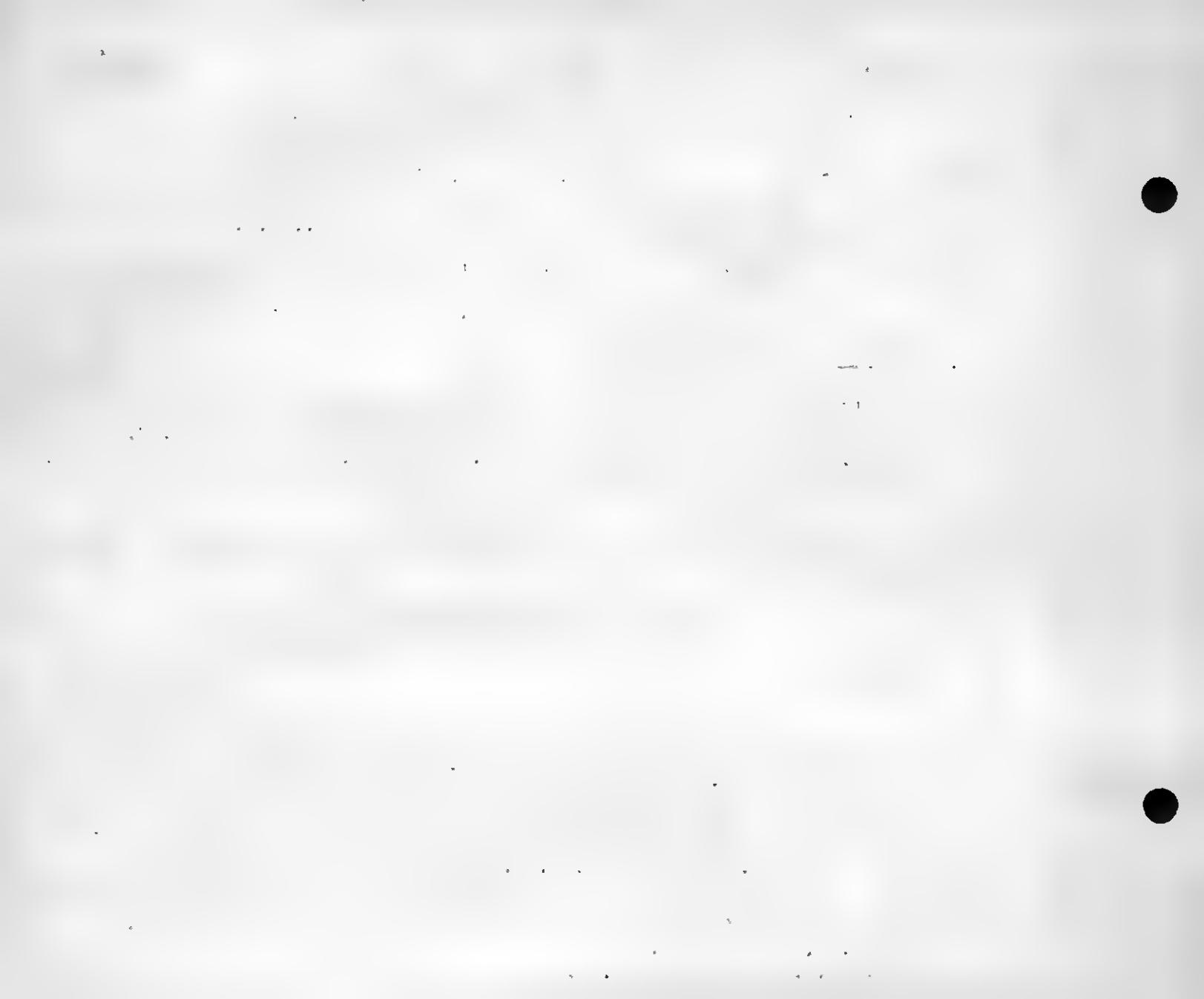
CERTIFICATE OF DEATH

17449

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or hospital director, page 3 should be detached for use as the burial-transit permit. This page should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>85 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 475	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>4634 47th St., N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles</b>	First	Middle	Lost	4. DATE OF DEATH <b>December 6 1966</b>	Month Doy Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 21, 1884</b>	9. AGE (In years last birthday) <b>81 yrs</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Marine Corp Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Marine Corp</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Philipsburg, Pennsylvania</b>	
13. FATHER'S NAME <b>John J. O'Connor</b>		14. MOTHER'S MAIDEN NAME <b>Isabelle McClellan</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <b>yes 1904-1930</b>		16. SOCIAL SECURITY NO <b>579 60 1178</b>		17. INFORMANT Washington Address D. C. Mrs. Louella C. O'Connor, 4634 47th St., NW	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, bronchial</i>				INTERVAL BETWEEN ONSET AND DEATH <b>86 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Sept.</i>		DUE TO (b) <i>Oclusion of Right Middle cerebral artery</i>			
DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <b>(s)</b> (this hospital) attended the deceased from <b>Sept. 12, 1966</b> , to <b>Dec. 6, 1966</b> that <b>(s)</b> (we) last saw the deceased alive on <b>Dec. 6, 1966</b> , and that death occurred at <b>1010A M</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>William L. Brannon, Jr.</b>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Dec. 6, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>William L. Brannon, Jr., M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b>		ADDRESS <b>3072 M St., N.W. Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>DEC 8 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17450

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M		17457		2 17450	
1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>MARYLAND</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>		c. LENGTH OF STAY IN 16 <i>46 hrs</i>		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>SUBURBAN</i>		e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Potomac</i>			
f. STREET ADDRESS <i>9807 Ever Rd</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
h. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Potomac Manor Nursing Home</i>					
3. NAME OF DECEASED (Type or print) <i>George SPENCE O'CONNOR</i>		First <i>G</i>	Middle <i></i>	Last <i>O'CONNOR</i>	4. DATE OF DEATH Month Day Year <i>Dec 27 1966</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>12/29/1890</i>	9. AGE (In years lost birthday) <i>75 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min. <i></i>
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None Retired</i>		11b. KIND OF BUSINESS OR INDUSTRY		11c. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Daniel O'Connor</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ann Spence</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Thelma Hodgin</i> Address <i>2215 University Blvd S. Seattle</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arterios and arteriovenous nephroclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>41</i> <i>Arteriosclerosis</i>		DUE TO (b) <i>Generalized arterosclerosis</i>		Years	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pulmonary emphysema and arteriosclerosis</i>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <i></i>				(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12/25 1966</i> , to <i>12/27 1966</i> , that (I) (we) last saw the deceased alive on <i>12/27 1966</i> , and that death occurred at <i>11:30 A.M.</i> from causes and on the date stated above.					
22a. SIGNATURE <i>Thelma Hodgin</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED <i>12/28/66</i>					
22c. PHYSICIAN'S NAME (Type) <i>THOMAS F. O'CONNOR</i>		22d. ADDRESS <i>8218 WISCONSIN AVE, BETHESDA, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 31-1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Towson Cemetery</i>	
23d. LOCATION (City or Town) <i>Baltimore</i>				(County) (State)	
24. FUNERAL-DIRECTOR <i>Arthur Kalters</i>		ADDRESS <i>254 Carroll St</i>		25a. REC'D BY REGISTRAR DATE JAN 3 1967	
				25b. REGISTRAR'S SIGNATURE <i>J. J. Kelly Jr.</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17458

## CERTIFICATE OF DEATH

17441

## 1. PLACE OF DEATH

## a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY N 1b

while RURAL and give nearest town)

Silver Spring

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Holy Cross Hospital

3. NAME OF  
DECEASED  
(Type or print)

Linda

Donna

Middle

## 5. SEX

Female

## 6. COLOR OR RACE

W

## 7. MARRIED

 NEVER MARRIED 

## WIDOWED

## DIVORCED

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

## 10b. KIND OF BUSINESS OR INDUSTRY

None

## 11. BIRTHPLACE County &amp; State or foreign country

Montgomery, Md

## 13. FATHER'S NAME

Donald W. Olson

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

## 16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)161  
Conditions, if any, which  
give rise to immediate cause  
(a), stating the underlying  
cause last.

None

Hospital Records

Address

Cerebral anoxia

umbilical cord around neck

INTERVAL BETWEEN  
ONSET AND DEATH

72 hours

at birth

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, notify MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year  
Hour a.m. While at work   
p.m. Not While at work 

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20d. INJURY OCCURRED  
20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)  
20f. (City or town)  
(County) (State)

## 21. I certify that (I) (this hospital) attended the deceased from Dec. 17, 1966, to Dec. 18, 1966, that (I) (we) last saw the deceased alive on Dec. 18, 1966, and that death occurred at 7 AM, from the causes and on the date stated above.

## 22a. SIGNATURE

22c. PHYSICIAN'S  
NAME (Type)

Herbert J. Friedel

11014 New Hampshire Av, Silver Spring

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

23b. DATE THEREOF Dec. 20, 1966

23c. NAME OF CEMETERY OR CREMATORIAL  
George Washington Cem. Adepine, 12 Bus Ct. Md.

23d. LOCATION (City, town or county) (State)

T.D.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS

Arthur Walters 254 Carroll St. Md.

25a. REC'D BY REGISTRAR DEC 21 1966

25b. REGISTRAR'S SIGNATURE

Judge



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 M  
FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 17451

1. PLACE OF DEATH a. CITY OR TOWN		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Montgomery</i>				a. STATE <b>Maryland</b>	b. COUNTY <b>Montgomery</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN MD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Takoma Park</i>		<i>4 years</i>		<i>Takoma Park</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>8523 Glenview Avenue</i>		<i>8523 Glenview Avenue</i>		Day 27 Year 1966	
3. NAME OF DECEASED (Type or print)		First <b>Etta</b>	Middle <b>Cardwell</b>	Last <b>Bessie Luenden</b>	4. DATE OF DEATH <b>December 27 1966</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1897</b>	9. AGE (In years at birth) <b>69 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Wyoming</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Edward Cardwell</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Dodds</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT <b>Mrs. Lucille Warncke</b> <i>4812 Western Ave. Chevy Chase, Md.</i>	
<b>No</b>		<b>None</b>		yes	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) <b>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)</b>		<b>Acute Coronary Insufficiency</b>			
DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		<b>Essential Hypertension</b>			
DUE TO <b>(b)</b>					
DUE TO <b>(c)</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Arlington</b>	(County) <b>Virginia</b> (State) <b>VA</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Belden R. Leach</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BELDEN R. LEACH M.D.</b>		DATE SIGNED <b>12/27/1966</b>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 30, 1966</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery</b>	22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>	(State) <b>VA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clark E. Wipor</b>		ADDRESS <b>8434 Georgia Ave.</b>	24a. REC'D. BY REGISTRAR <b>Jan 3 1967</b>	24b. REGISTRAR'S SIGNATURE <b>Judge</b>	
VS. A15ME 5M 2/57					



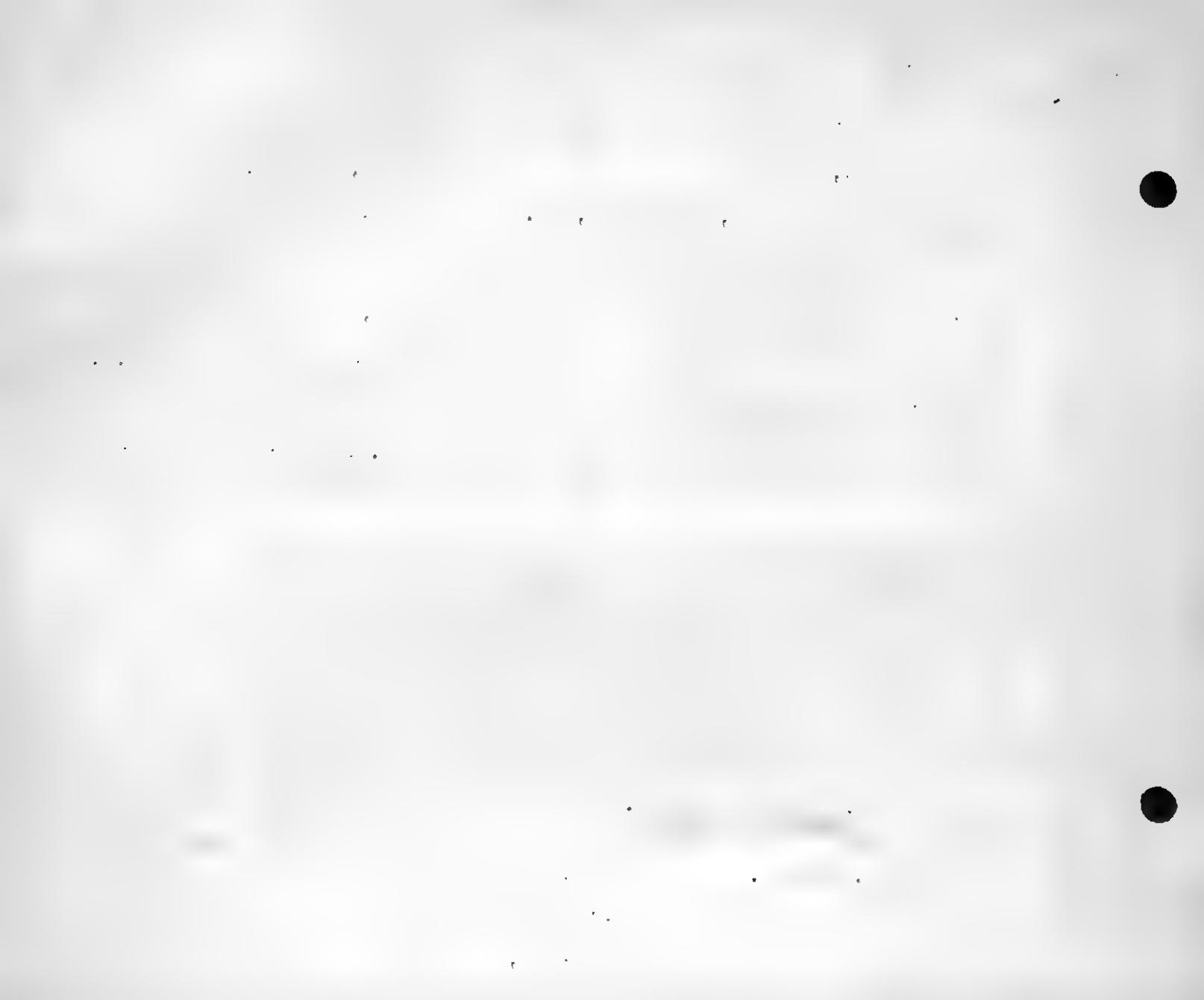
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17460 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17452

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY -		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Rockville, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
100 Dawson Avenue, Rockville, Md.		100 Dawson Avenue Apt#51 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Walter		B	O'Quinn
4. DATE OF DEATH		Month	Day Year
December 3 1966			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.	
September 8 1896		70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Farmer		Virginia	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Unknown -- Hagy		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Billy -- William O'Quinn		Charles O'Quinn same item #2 -Son	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
Yes WWI		227-22-2992 Charles O'Quinn same item #2 -Son	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Sept 8-1966	
420.1		Coronary Insufficiency	
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>John G. Ball</i>		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John G. Ball Bethesda, Maryland		22. DATE SIGNED 12/3/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/8/66	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National
23d. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Maryland		RECD BY REGISTRAR DEC 7 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17461

## CERTIFICATE OF DEATH

17453

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If you please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c LENGTH OF STAY IN lb 68 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Naval Hospital (Bethesda)		d. STREET ADDRESS 4890 Battery Lane, Apt. 416	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print)	First Reuben	Middle Noel	4. DATE OF DEATH December 5 1966
S SEX Male	6 COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 6, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Military		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 76 yrs
11. BIRTHPLACE (County & State, or foreign country) Melrose, Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Horace E. Perley		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes 1911-37, 1941-48		16. SOCIAL SECURITY NO. 255 46 3522	Apt. 416 Bethesda, Address Md. Mrs. Anne L. Perley, 4890 Battery Lane
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Pancreas		INTERVAL BETWEEN ONSET AND DEATH	
157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c)		DUE TO	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (b) (this hospital) attended the deceased from Sept. 28, 1966, to Dec. 5, 1966 that (b) (we) last saw the deceased alive on Dec. 5, 1966, and that death occurred at 310PM, from causes and on the date stated above.			
22a. SIGNATURE Francis D. Keenan Jr., M.D.		22b. DATE SIGNED Dec. 6, 1966	
22c. PHYSICIAN'S NAME (Type) Francis D. Keenan, Jr., M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-7-1966	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (State)		Suitland, Maryland	
24. FUNERAL DIRECTOR Joseph Gawler & Sons, 5130 Wisconsin Ave., N.W., Washington, D.C.		25a. REC'D BY REGISTRAR DATE DEC 14 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17462		17454	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY <u>Montgomery</u>		b. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN b <u>9 days.</u>	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Silverwood Hospital</u>		d. STREET ADDRESS <u>6500 Kenney Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Edward A. Perry</u>		4. DATE OF DEATH <u>12 15 64</u>	
5. SEX <u>M.</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		8. DATE OF BIRTH <u>8/24/90</u>	
9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		10. AGE (In years last birthday) <u>72 yrs</u>	
11. IF UNDER 1 YEAR Months <u>0</u>		12. IF UNDER 24 HRS Hours <u>0</u>	
13. FATHER'S NAME <u>Edward A. Perry Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Avery</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/> If yes give war or dates of service <u>Yes WW I</u>		16. SOCIAL SECURITY NO <u>106-12-5700</u>	
17. INFORMANT <u>Wife Ruth E. Perry</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Coronary arteriosclerosis</u> DUE TO (c)	
		19. INTERVAL BETWEEN DEATH AND DEATH <u>72 hrs.</u>	
20. MEDICAL CERTIFICATION		21. PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) EXPLANATION EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part I of item 18) TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED Wh. e. Not White of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>12/17/66</u>	
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-20-66</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>Arlington Natl Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. ADDRESS 25b. REC'D BY REGISTRAR DATE <u>DEC 22 1966</u>	
		25c. REGISTRAR'S SIGNATURE <u>Robert J. Pumphrey</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17463

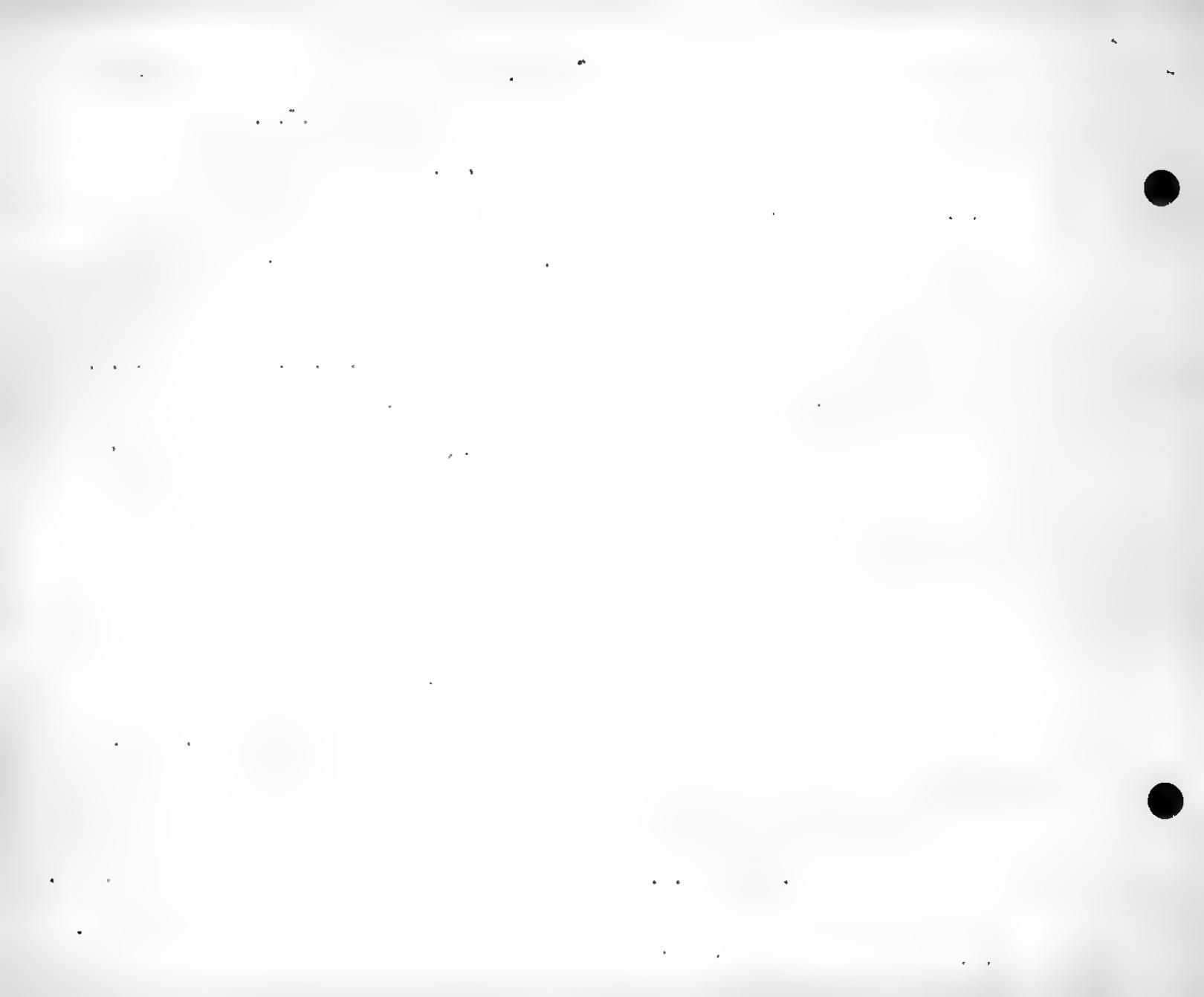
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17455

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a STATE BERMUDA, B.W.I. b COUNTY	
b CITY OR TOWN (If outside corporate limits, write BETHESDA, MD.) c LENGTH OF STAY IN lb 2 DAYS		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) U. S. NAVAL STATION, BERMUDA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL, BETHESDA, MD.		d STREET ADDRESS	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First MARJORIE	Middle DAWN	Last PETERSON
4 DATE OF DEATH	Month DECEMBER	Day 17	Year 66
S SEX FEMALE	6 COLOR OR RACE CAUCASION	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7 AUGUST 1966
9 AGE (in years last birthday) 4 yrs	10 IF UNDER 1 YEAR Months 10	11 IF UNDER 24 HRS Days 10	12 IF UNDER 24 HRS Hours Min
10a OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b KIND OF BUSINESS OR INDUSTRY NA	
11 BIRTHPLACE (State or foreign country) BERMUDA, B. W. I.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME DOUGLAS PETERSON		14 MOTHER'S MAIDEN NAME VIVIAN J. HOOVER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO NA	
17 INFORMANT VIVIAN J. PETERSON "BY THE WAY APTS"		Address SOMERSET, BDA	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL EDEMA ASSOCIATED WITH SUBDURAL HEMATOMA		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
9020 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) (c)		DUE TO	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) FELL OFF COUGH HITTING HEAD	
20c TIME OF INJURY Month, Day, Year Hour a.m. 4:30pm p.m. 13 DEC 19 66		20d INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> off work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm factory, street, office building, etc.) HOME		20f (City or town) (County) (State) BERMUDA, B. W. I.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JOHN G. BALL, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12-19-66	
23c NAME OF CEMETERY OR CREMATORIAL Greenhill Cemetery		23d LOCATION (City or Town) (County) (State) Waynesboro, Penna.	
24. FUNERAL DIRECTOR R.A. PUMPHREY, 7557 WISC. AVE.		ADDRESS BETHESDA, MD	
25a. REC'D BY REG STAR DATE 12 EC 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17464

## CERTIFICATE OF DEATH

17456

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>D.C.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	b. COUNTY <i>N.W. D.C.</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>	d. STREET ADDRESS <i>4050 Fessenden St.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Marguerite Pfleiger</i>	First <i>Marguerite</i>	Middle <i>Pfleiger</i>	Last <i>Marguerite Pfleiger</i>				
4. DATE OF DEATH <i>12-20</i>	Month <i>Dec.</i>	Day <i>20</i>	Year <i>1966</i>				
5. SEX <i>F</i>	6. COLOR OR RACE <i>Br.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>Nov. 24, 1903</i>	9. AGE (In years since birthday) <i>65 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i>	12. IF UNDER 24 HRS Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Receiving Clerk Relief</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>			
13. FATHER'S NAME <i>William A. Myers</i>	14. MOTHER'S MAIDEN NAME <i>Roberta Groves</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO <i>579-42-4697</i>	17. INFORMANT <i>Son-Chester John - Bethesda, Md.</i>	Address <i>9218 Shetton St.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobar pneumonia, entire right lung</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>-17</i>							
(b) DUE TO <i></i>							
(c) <i></i>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bullous emphysema, left upper lobe, lung</i>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or item 18.) <i></i>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>	
21. I certify that (I) (this hospital) attended the deceased from <i>12/1/66</i> , to <i>12/20/66</i> , that (I) (we) last saw the deceased alive on <i>12/10/66</i> , and that death occurred at <i>11:00 PM</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>Dr Joseph P. Kenrick</i>		M.D. <input type="checkbox"/>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>12/20/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Dr JOSEPH KENRICK</i>		22d. ADDRESS <i>6450 Wisconsin Ave, Bethesda, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-23-66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cemetery</i>	23d. LOCATION (City or Town) <i>Washington, D. C.</i>	(County) <i></i>	(State) <i></i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS <i></i>		25a. REC'D. BY REGISTRAR <i>REC'D. 27 1966</i>	25b. REGISTRAR'S SIGNATURE <i></i>		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17465

## CERTIFICATE OF DEATH

17457

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			b. COUNTY <i>Silver Spring</i>		
c. LENGTH OF STAY IN b <i>19 days</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>515 Thayer Ave; Apt. 104</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium + Hospital</i>			d. STREET ADDRESS <i>515 Thayer Ave; Apt. 104</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Mr. Ernest Andrew Phillips</i>			4. DATE OF DEATH Month Day Year <i>12-23 = 1966<sup>19</sup></i>		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <i>Divorced</i>	8. NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>10-27-90</i>
9. AGE (in years last birthday) <i>76 yrs</i>		10. KIND OF BUSINESS OR INDUSTRY <i>Retired - Clothing Salesman</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Mass.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Andrew Phillips</i>			
14. MOTHER'S MAIDEN NAME <i>Elizabeth O'Brien</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>No</i>			
16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>151X</i>			INTERVAL BETWEEN ONSET AND DEATH <i>never</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i></i>			DUE TO (b) DUE TO (c) <i>You tell them! ASTH = an. fib</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cong failure. Due to cause of ASTH</i>			4-5 yrs		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <i></i>	
20f. (City or town) <i></i>		(County) <i></i>		(State) <i></i>	
21. I certify that (I) (this hospital) attended the deceased from <i>12/4/66</i> , to <i>12/23/66</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>5:50 AM</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>Chas H. W. Lotion</i>			22b. DATE SIGNED <i></i>		
22c. PHYSICIAN'S NAME (Type) <i>Chas H. W. Lotion MD</i>			22d. ADDRESS <i>831 Remo. Blvd E. Silver Spring</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>12-23-1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Hope Cemetery</i>	
24. FUNERAL DIRECTOR <i>Joseph J. Fowler's Sons, Inc.</i>		ADDRESS <i>5130 Rockville Ave. N.W., Wash. DC.</i>		25d. REC'D BY REGISTRAR DATE <i>DEC 23 1966</i>	
25e. REGISTRAR'S SIGNATURE <i>Lori's Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

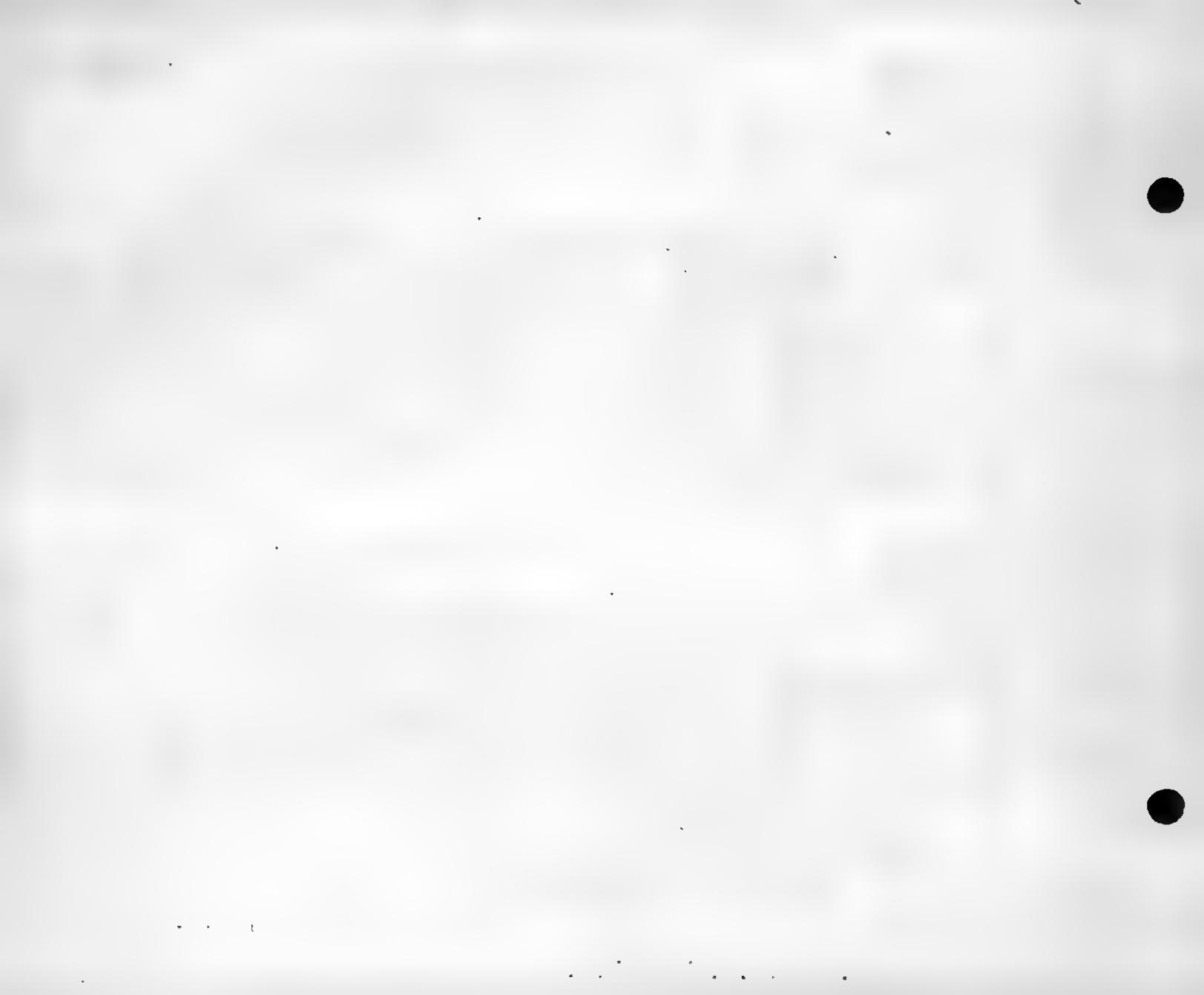
CERTIFICATE OF DEATH

17459

17467

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE	
<i>Montgomery Maryland</i>		<i>Maryland Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB <i>Bethesda</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. STREET ADDRESS <i>Suburban Bethesda 5012 Acacia Avenue</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year <i>First Middle Last 12-21 1966</i>	
S. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED
<i>F</i>	<i>RU</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>LIBRARIAN</i>		<i>LIBRARY of Cong NEW YORK</i>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>New York</i>		<i>USA</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Stephen Day Pierson</i>		<i>Phoebe Dusinberre</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>- - -</i>	
17. INFORMANT		Address <i>Bethesda, Md. Isabel Phillips, 5012 Acacia Ave.</i>	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
<i>Spontaneous Subarachnoid Hemorrhage</i>			
DUE TO <i>33IX</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)		4 days	
DUE TO <i>Cerebral-Vascular Accident</i>			
(c) <i>Arteriosclerosis, generalised</i>		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 1963, to 12-21-1966, that (I) (we) last saw the deceased alive on Dec 21 1966, and that death occurred at 2 <sup>nd</sup> P.M. from causes and on the date stated above.		22b. DATE SIGNED <i>12-21-66</i>	
22a. SIGNATURE <i>Stewart Clapp</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Stewart Clapp MD</i>		22d. ADDRESS <i>4740 Chevy Chase Dr. Chevy Chase Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>12-23-1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Florida, N.Y.</i>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i>		ADDRESS <i>5130 Wisconsin Ave. N.W. Wash. D.C.</i>	
25a. REC'D. BY REGISTRAR <i>DEC 22 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 3 Film 3284 16/30/66 mb											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>						2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <i>Bethesda</i>						c. LENGTH OF STAY IN b <i>DOA</i>					
d. NAME OF HOSPITAL OR INSTITUTION [If not in hospital, give street address] <i>Schubert Cogill &amp; Farley Ltd</i>						e. STREET ADDRESS <i>11606 Joseph Mill Road</i>					
3 NAME OF DECEASED First <i>Thomas</i> Middle <i>James</i> Last <i>Reese</i>						4 DATE OF DEATH Month <i>12</i> Day <i>13</i> Year <i>1966</i>					
5 SEX <i>m</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 28 1906</i>		9. AGE (In years last birthday) <i>60 yrs</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (G ve kind of work done during most of working life, even if retired) <i>taxicab driver</i>						10b. KIND OF BUSINESS OR INDUSTRY <i>Automobile</i>					
11. BIRTHPLACE (State or foreign country) <i>Kansas</i>						12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Franklin</i>						14. MOTHER'S MAIDEN NAME <i>Frances Reed</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes May 1941</i>						16. SOCIAL SECURITY NO <i>516-03-4324</i>					
17. INFORMANT <i>Ann Reese</i>						18. ADDRESS <i>Home ad adron # 2</i>					
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>400.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)						20. INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1b) 20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <i>19</i>					
20d. INJURY OCCURRED Wh. at work <input type="checkbox"/> Not Wh. at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm factory, street, office b dg, etc.) 20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John G. Ball</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>7936 Old Georgetown Rd. Bethesda, Md.</i>					
22. DATE SIGNED <i>12/13/66</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>						23b. DATE THEREOF <i>Dec. 16, 1966</i>					
23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National Cem.</i>						23d. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>					
24. FUNERAL DIRECTOR <i>C. Glen Carter Cremation Inc.</i>						25a. ADDRESS <i>8434 Georgia Ave.</i>					
25b. REC'D. BY REGISTRAR <i>Warren E. Pumphrey, Inc.</i>						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
25c. DATE <i>DEC 20 1966</i>											



FOR STATE  
HEALTH DEPT.If any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page  
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

17468

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17461

## 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Kensington

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

10600 Conn Ave

3. NAME OF  
DECEASED  
(Type or print)

First George Dewey Pine

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED  
WIDOWED8. NEVER MARRIED  
DIVORCED10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

RETIRED

10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

OHIO

12. CITIZEN OF WHAT  
COUNTRY?

AMER.

13. FATHER'S NAME

LOUIS PINE

14. MOTHER'S MAIDEN NAME

MARY FULLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO

223-05-20621

17. INFORMANT

wife - mrs Ograda Pine

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

430.1

Acute coronary insufficiency

INTERVAL BETWEEN  
ONSET AND DEATHConditions, if any, which gave  
rise to immediate cause (a),  
stating the underlying cause  
last.

DUE TO

(b)

DUE TO

(c)

Arteriosclerotic heart disease

## MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m. 19

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20d. INJURY OCCURRED  
While  Not While   
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

23a. DATE THEREOF

12/9/66

23c. NAME OF CEMETERY OR CREMATORIUM

Mt. Pleasant Cemetery

23d. LOCATION (City or Town)  
(County) (State)CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 

Address (Street, city, town or county)

22. DATE SIGNED

Dec. 6, 1966

24. FUNERAL DIRECTOR

300 4th St., NE

J. Wm. Lees Sons Washington, DC

ADDRESS

300 4th St., NE

J. Wm. Lees Sons Washington, DC

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

17461

17469

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH o COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Montgomery Silver Spring		c LENGTH OF STAY IN 1b		o STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Holy Cross Hospital		Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 504 Blandford St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Paul		First MIDDLE EDWARD		4 DATE OF DEATH 12/8 Month Day Year 1966	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1938 9/27/37	9 AGE (in years 28 yrs lost b/day)	IF UNDER 1 YEAR Months Doy Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office management		10b KIND OF BUSINESS OR INDUSTRY Dowell Pile Co.		11 BIRTHPLACE (County & State, or foreign country) West Virginia	
13 FATHER'S NAME Charles Ivan Poe, Sr.		14 MOTHER'S MAIDEN NAME Ruby Howell		12 CITIZEN OF WHAT COUNTRY? U.S.A	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO 232-58-5691		17. INFORMANT Wife Patricia Ann Poe Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY		INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>JVTA</b>		DUE TO			
(b) <b>GUILAIN-BARRE SYNDROME</b>		DUE TO			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>NONE</b>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 13, 1966 to Dec 8, 1966, that (I) (we) last saw the deceased alive on 12/8/66, and that death occurred at 1139 M, from causes and on the date stated above.					
22a SIGNATURE		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/9/66	
22c PHYSICIAN'S NAME (Type) Francis G. Mayle, M.D.		22d. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 12-9-66		23b DATE THEREOF 12-9-66		23c NAME OF CEMETERY OR CREMATORIAL Presbyterian Cemetery East Dailey, W. Va.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a REC'D BY REGISTRAR DATE DEC 15 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Form 384 12/22/66 mh

17470

## CERTIFICATE OF DEATH

17462

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>FLORIDA</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE</u>		c. LENGTH OF STAY IN lb <u>5 1/2 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BETHESDA SILVER SPRING NURSING HOME</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAYTONA BEACH</u>	
3. NAME OF DECEASED (Type or print) <u>AURORA MILLER POSTON</u>		d. STREET ADDRESS <u>303 RIVERSIDE DR.</u>	
3. NAME OF DECEASED (Type or print) <u>AURORA MILLER POSTON</u>		4. DATE OF DEATH Month <u>DECEMBER 13</u>	Year <u>1966</u>
S SEX <u>FEMALE</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		9. DATE OF BIRTH <u>March 13, 1888</u>	
10a. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>78 yrs.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>OREGON</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>George McA Miller</u>		14. MOTHER'S MAIDEN NAME <u>AdeLine Dickman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Son</u>		18. Address <u>Excother George Edwards Same as Item 2.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>		20. INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
DUE TO <u>JAIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>lost.</u>			
(b) <u>Cerebral Atherosclerosis 85 years</u>			
DUE TO <u>Generalized Atherosclerosis</u>			
21. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		22. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>8641 Colesville Rd., Silver Spring</u>
20f. (City or town) <u>8641 Colesville Rd., Silver Spring</u>		(County) <u>Montgomery</u>	
		(State) <u>MD</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12/12/66</u> to <u>12/13/66</u> , that (I) (we) last saw the deceased alive on <u>12/12/66</u> , and that death occurred at <u>11:45 P.M.</u> from causes and on the date stated above.		22b. DATE SIGNED <u>12/13/66</u>	
22a. SIGNATURE <u>G. LEONARD GOLD</u>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. ADDRESS <u>8641 Colesville Rd., Silver Spring</u>
23a. BURIAL, CREMATION, REMOVALS (check) <u>BURIAL</u>		23b. DATE THEREOF <u>Dec. 16, 1966</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Ruskin Memorial Pk., Ruskin, Florida</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	25a. REC'D. BY REGISTRAR DATE <u>DEC 15 1966</u>
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17471

CERTIFICATE OF DEATH

17463

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or burial, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>1 days</i>	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <i>Washington San. &amp; Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>905 Fairview Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Josephine Mildred Pavlos</i>		d. STREET ADDRESS <i>Takoma Park, Md.</i>	
4. DATE OF DEATH Month Day Year <i>Dec. 10 1966</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 4, 1901</i>	
9. AGE (In years last birthday) yrs <i>65</i>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUA. OCC. PATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <i>Brown's Town, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
13. FATHER'S NAME <i>John Herremann</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>186-26-4000B</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO (b) <i>Cardio res. failure due to pos</i> DUE TO (c) <i>met. Ca lymphangitic lung infarct n 3-4 mo</i> <i>Hammam Shiki Syndrome</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-3</i> , 19 <i>66</i> , to <i>12-10</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>12-10</i> , 19 <i>66</i> and that death occurred at <i>12-10</i> M. from causes and on the date stated above		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <i>Vicente C. deGuzman</i>		22b. DATE SIGNED <i>12-10-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>VICENTE C. deGuzman</i>		22d. ADDRESS <i>1234 19 NW Wash DC.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>12/13/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges County, Md.</i>	
24. FUNERAL DIRECTOR <i>J.H. Series Co. 2901-14 N.W. D.C.</i>		ADDRESS	
		25a. RECD BY REGISTRAR DATE <i>DEC 15 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17464

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1 PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)</b>						
a. COUNTY <b>Montgomery</b> MARYLAND				a. STATE <b>Maryland</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oiney</b>		c. LENGTH OF STAY IN lb <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		b. COUNTY <b>Montgomery</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>Norbeck Road</b>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First <b>Emma</b>	Middle <b>Jane</b>	Last <b>Powell</b>	4 DATE OF DEATH <b>December 8, 1966</b>	Month <b>December</b>	Day <b>8</b>	Year <b>1966</b>		
5. SEX <b>Female</b>		6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6/25/93</b>	9 AGE (In years last birthday) <b>73 yrs</b>	10 IF UNDER 1 YEAR Months <b>0</b>	11 IF UNDER 24 HRS Days <b>0</b>	12 Hours <b>0</b>	13 Min <b>0</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unkn.</b>				10b KIND OF BUSINESS OR INDUSTRY				11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		
13. FATHER'S NAME <b>Unkn.</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Jane</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Hospital Records</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ENCEPHALOMALARIA - PAREITAL</b> Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>CAROTID ARTERY Occlusion</b> Last (b) Due to (c) Due to <b>GENERAL ARTERIOSCLEROSIS</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>DIABETES HELITUS</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)						
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>July 1965 to 12/8/66</b>	(County) <b>1966</b>	(State) <b>1966</b>		
21. I certify that (1) (this hospital) attended the deceased from <b>July 1965 to 12/8/66</b> , 1966, that (1) (we) last saw the deceased alive on <b>12/8/66</b> , and that death occurred at <b>9:15 AM</b> , from causes and on the date stated above										22b. DATE SIGNED
22a. SIGNATURE <b>Donald F. Lewis</b>				M.D. <input type="checkbox"/> ATTENDING PHYSICIAN	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22d. ADDRESS <b>Medical Center, Sandy Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>12/12/66</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Hsh Memorial</b>		23d. LOCATION (City or Town) <b>Sandy Spring</b>		(County) <b>Md</b>		
FUNERAL DIRECTOR <b>Robert L. Snodden</b>		ADDRESS <b>Rockville, Md.</b>		25a. RECD BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE				
DATE <b>DEC 15 1966</b>										



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17473

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17465

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>21 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital of Silver Spring</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>John</b>	Middle <b>T</b>	Last <b>Prendergast</b>
4. DATE OF DEATH <b>12/21</b>	Month <b>12</b>	Day <b>21</b>	Year <b>1966</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/12/86</b>
9. AGE (In years last birthday) <b>80 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Locamotive Co.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>Thomas Prendergast</b>	14. MOTHER'S MAIDEN NAME <b>Winifred Concannon</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>166-09-5354</b>	17. INFORMANT <b>King Funeral Home, Phila., Penna.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Acute, Subacute, & Chronic Pericarditis			
INTERVAL BETWEEN ONSET AND DEATH <b>Multiple Pulmonary Emboli</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Yeadon, Delaware, Penna.</b>
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and In my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
Address (Street, city, town, or county) <b>13/21/1966</b>			
22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/27/66</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Holy Cross Cemetery</b>
23d. LOCATION (City, town or county) (State) <b>Yeadon, Delaware, Penna.</b>			
24a. FUNERAL DIRECTOR <b>John E. Murphy, Inc., 8434 Ga. Ave., S.S., Md.</b>		24b. ADDRESS <b>1101 E. Purpley, Inc., 8434 Ga. Ave., S.S., Md.</b>	25a. REC'D BY REGISTRAR <b>REG</b>
25b. REGISTRAR'S SIGNATURE <b>13/21/1966</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17474

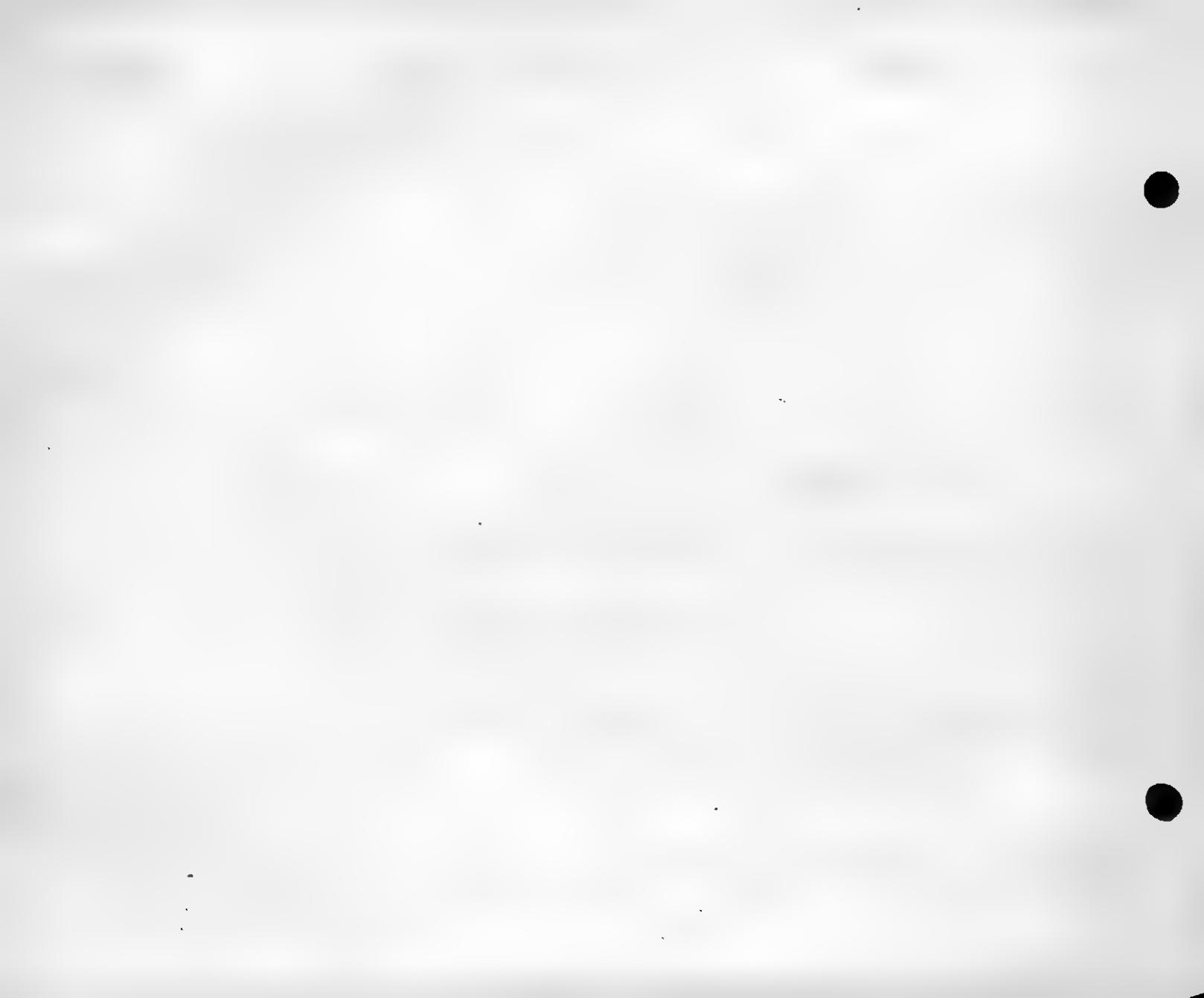
CERTIFICATE OF DEATH

17466

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Holstomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>10 bds</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital of Silver Spring</i>		e. STREET ADDRESS <i>1006 So Belgrade Rd</i>	
3. NAME OF DECEASED (Type or print) <i>Amanda</i>		First <i>LARSEN</i>	Middle <i>Prince</i>
4. DATE OF DEATH <i>Dec 11 1966</i>	Month <i>Dec</i>	Day <i>11</i>	Year <i>1966</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH <i>8/24/80</i>		9. AGE (In years lost birthday) <i>86 yrs</i>	10. IF UNDER 1 YEAR Months <i>11</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Illinoi</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>CHARLES PEYER LARSEN</i>	
14. MOTHER'S MAIDEN NAME <i>ELIZABETH THAISEN</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>	
16. SOCIAL SECURITY NO. <i>213-56-7502</i>		17. INFORMANT <i>CHARLES WAGNER SAME AS #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. <i>Congestive Heart Failure</i>		DUE TO (c) <i>arterio sclerotic heart disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>abdominal pain - loose stools - tarry stools -呕血</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>9911 PA. AVE. S.S. MD.</i>
20f. (City or town) <i>CHICAGO, IL.</i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____ M, from causes and on the date stated above.			
22a. SIGNATURE <i>Merton L. White</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>12/11/66</i>
22c. PHYSICIAN'S NAME (Type) <i>MERTON L. WHITE</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12/14/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>OAK WOODS</i>
24. FUNERAL DIRECTOR <i>W.W. CHAMBERS CO.</i>		25a. ADDRESS <i>8655 8TH AVE.</i>	25b. LOCATION (City or Town) <i>CHICAGO, IL.</i>
		25c. RECEIVED BY REGISTRAR <i>DEC 15 1966</i>	25d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



Cleared with Medical Examiner  
S.L. Wilson

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17475

## CERTIFICATE OF DEATH

17467

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery Takoma Park		b. COUNTY Fayette	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
11 months		Masontown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Oakhaven Convalescent 7 home -		8050 Woodlawn Dr. S. Main St.	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Charles Alexander Provance		Month 12 - 27	
Middle		Day Year 1966	
Last			
5. SEX		6. COLOR OR RACE	
M		W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	
Mail carrier		INDUSTRY U.S. Post	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Alexander Provance		Pa.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		14. MOTHER'S MAIDEN NAME	
No		Tabitha Mc Cann	
16. SOCIAL SECURITY NO.		Address	
17. INFORMANT		Takoma Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Several Hours	
Cerebral Vascular Accident			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			
(b) Severe Generalized Arteriosclerosis		Several Years	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1966, to 12-27 1966, that (I) (we) last saw the deceased alive on 11-19 1966, and that death occurred at 6:30 PM, from the causes and on the date stated above.		22b. DATE SIGNED 12-27-66	
22a. SIGNATURE Stuart L. Nelson		ATTENDING M.D. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Stuart L. Nelson, M.D.		22d. ADDRESS 831 University Blvd East Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/66	
23c. NAME OF CEMETERY OR CREMATORIUM Masontown		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR John Thomas		ADDRESS	
Warren E. Pumphrey, Inc. 8434 Ga. Ave., S.S., Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 3 1967 J. Miles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17476

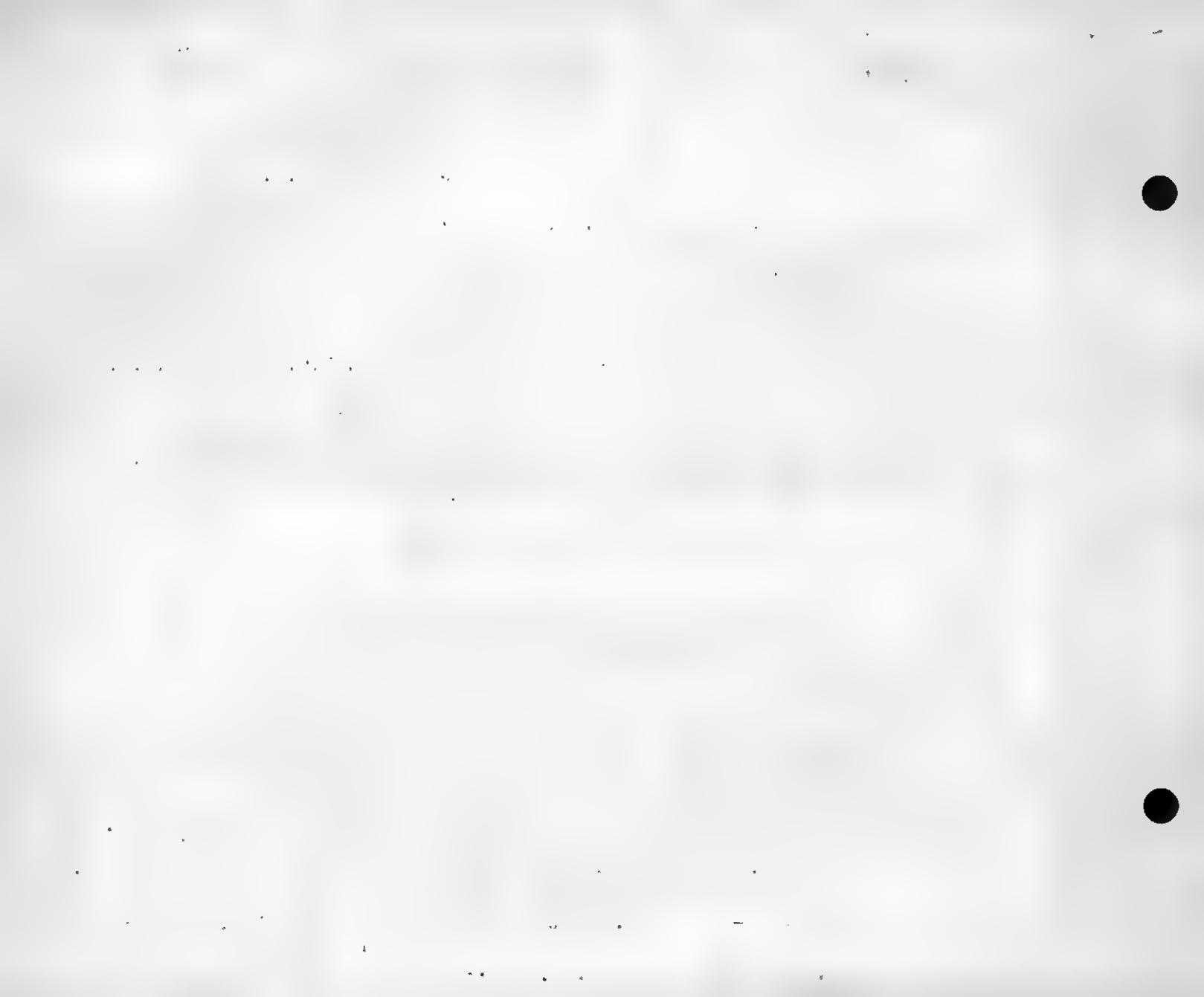
CERTIFICATE OF DEATH

17468

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~top~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <b>Washington, D.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>22 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>		d. STREET ADDRESS <b>4714 Temple Hills Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md. 20014</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marilyn</b>		First <b>Ann</b>	Middle <b>Pyles</b>
4. DATE OF DEATH <b>December 21 1966</b>	Last <b>December 21 1966</b>	Month <b>December</b>	Day <b>21</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>16 August 1950</b>	9. AGE (in years last birthday) <b>16 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>Carlton Pyles</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Elmore</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>Not available</b>	17. INFORMANT <b>The Medical Record</b> , Address <b>The Clinical Center, Bethesda, Md. 20014</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Cardio-respiratory arrest			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause <b>Pneumothorax</b>		16 years	
(b) Cystic Fibrosis of Pancreas			
(c) Bilateral Pneumothorax		Right <b>2 days</b>	Left <b>14 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Oxon Hill, Maryland</b>
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>29 November 1966</b> to <b>21 December 1966</b> to <b>1055 M</b> , fram causes and on the date stated above.			
22a. SIGNATURE <b>Charles E. Becker, M.D.</b>		M.D. ATTENDING PHYS. <input type="checkbox"/>	A. 22b. DATE SIGNED <b>21 Dec. 1966</b>
22c. PHYSICIAN'S NAME (Type) <b>Charles E. Becker, M.D.</b>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22d. ADDRESS <b>National Institutes of Health, The Clinical Center, Bethesda, Md. 20014</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 24-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Barnabas Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Oxon Hill, Maryland</b>
24. FUNERAL DIRECTOR <b>Simmons Bros</b>	ADDRESS <b>Simmons Bros. 1661- Good Hope Rd. SE, Wash., DC</b>	25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. George</b>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

17477

CERTIFICATE OF DEATH

17469

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>14 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>Jacob</b>		First <b>J</b> , Middle <b>A</b> , Last <b>Rand</b>	4. DATE OF DEATH Month <b>December</b> , Day <b>1</b> , Year <b>1966</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>Not known</b>		11. BIRTHPLACE (County & State or foreign country) <b>Austria</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>218-32-2331-A</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>7600 Carroll Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Thrombo, Dehydration &amp; CVA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>592X</b>		INTERVAL BETWEEN ONSET AND DEATH	
(b) <b>Chronic Renal Disease - &amp; Arteriosclerosis Chronic</b>			
(c) <b>Aging process.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 8.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <b>Nov 30 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b> (County) <b>Maryland</b> (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 30</b> , 1966, to <b>Dec 1</b> , 1966, that (I) (we) last saw the deceased alive on <b>Nov 30</b> , 1966, and that death occurred at <b>4A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Russell C. Bufalino</b>		22b. DATE SIGNED <b>Dec 1, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Russell C. Bufalino, M.D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>1429 University Blvd. Silver Spring</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/2/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Harford 1.02</b>		23d. LOCATION (City or Town) <b>Baltimore</b> (County) <b>Maryland</b> (State)	
24. FUNERAL DIRECTOR <b>Silver Spring Crematorium Inc.</b>		25a. REC'D BY REGISTRAR <b>REC'D DEC 5 1966</b>	
ADDRESS <b>1429 University Blvd. Silver Spring</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

(M)

17478

## CERTIFICATE OF DEATH

17470

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>			2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			c LENGTH OF STAY IN 1b <i>13 month</i>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Congressional Manor Sanitarium</i>			e STREET ADDRESS <i>5404 Harwood Road 9200 Rockville Pike, Bethesda, Md.</i>		
f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <i>Lelia A. Randall</i>			First	Middle	Lost
4. DATE OF DEATH <i>Dec. 12 1966</i>			Month	Day	Year
S. SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-15-1881</i>	9. AGE (In years lost birthday) <i>85 yrs.</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <i>New York</i>	
13. FATHER'S NAME <i>William Nourse</i>			14. MOTHER'S MAIDEN NAME <i>Hattie Snover</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>			16. SOCIAL SECURITY NO. <i>XX XX</i>		
17. INFORMANT <i>Nelda Creagh, 5404 Harwood Rd., Bethesda, Md.</i>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bulimia edema</i>			INTERVAL BETWEEN ONSET AND DEATH		
DUE TO (b) <i>Arteriosclerosis heart disease</i>					
DUE TO (c) <i>Diffuse arteriosclerosis</i>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>chronic bronchitis w/o t clogged arteries</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>Obear</i>	
20f. (City or town) <i>Obear</i>		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 12, 1965</i> , to <i>Dec. 12, 1966</i> , that (I) (we) last saw the deceased alive on <i>Dec. 12, 1966</i> , and that death occurred at <i>4:50 PM</i> , from causes and on the date stated above.			22b. DATE SIGNED <i>Dec. 12, 1966</i>		
22a. SIGNATURE <i>JACK KLETH M.D.</i>			22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>915 19th St. N.W.</i>		
23. FUNERAL CREMATION REMOVAL (Specify) <i>Scared</i>		23b. DATE THEREOF <i>12-12-66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Obear</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawlers Son's Inc Wash. D.C.</i>		ADDRESS <i>1100 Connecticut Ave. N.W.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 19 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. The please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17479

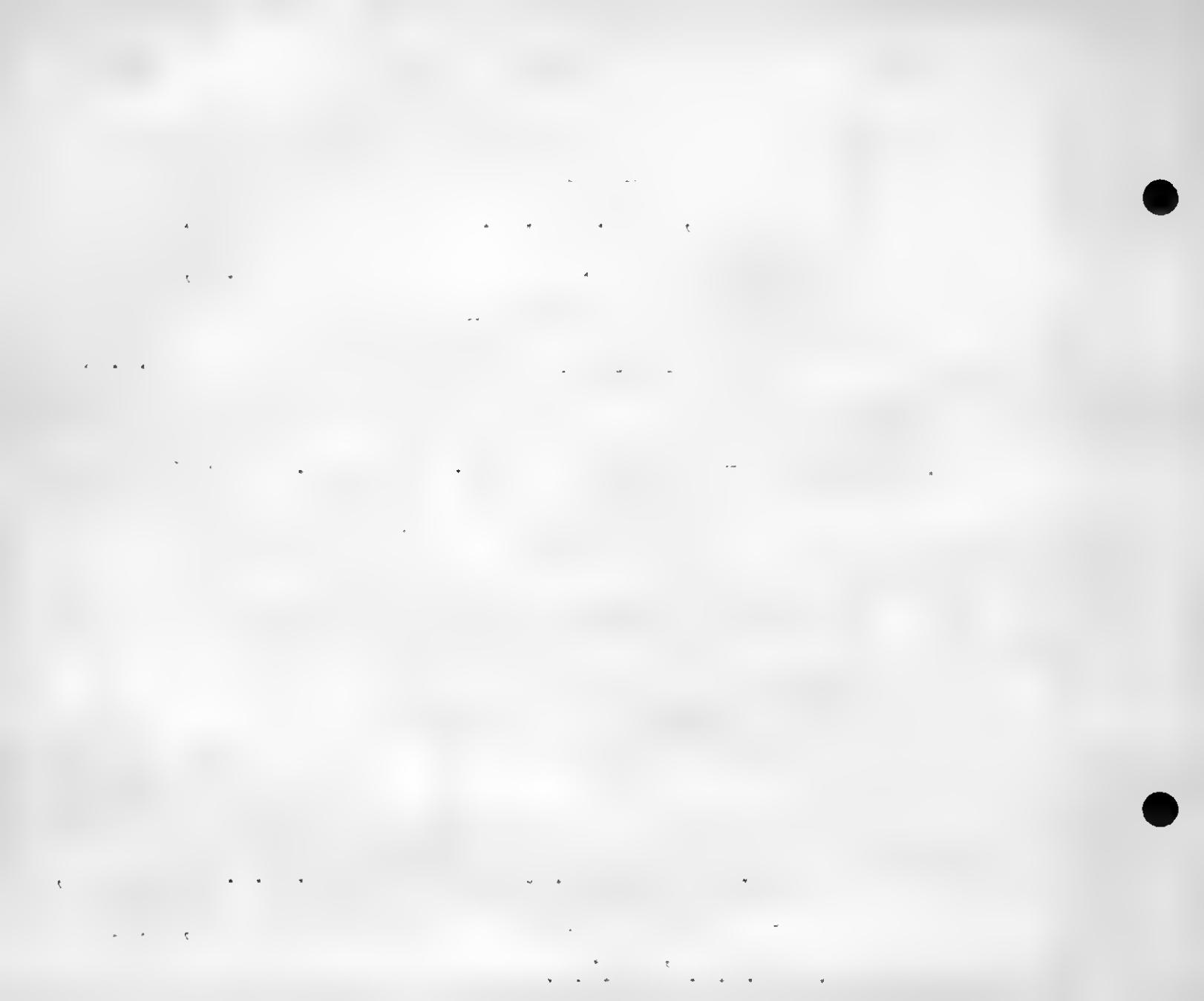
## CERTIFICATE OF DEATH

17471

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c LENGTH OF STAY IN TB - - -		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		d. STREET ADDRESS <b>800 University Blvd, East. Apt. 2.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>800 University Blvd, East. Apt. 2.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First <b>F.</b>	Middle <b>RAYMOND</b>	Lost	4. DATE OF DEATH <b>Dec. 9,</b>	Month <b>19</b>	Day <b>66</b>
S SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>2-18-1888</b>	9 AGE (In years last birthday) <b>78 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b KIND OF BUSINESS OR INDUSTRY - - -		11 BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>George Raymond</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Crawford</b>		Address			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No. - - -		16 SOCIAL SECURITY NO. <b>577-12-9744</b>		17. INFORMANT <b>Mrs. Mildred E. Raymond- See Item 9</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Memory</i>				INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>	
X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b)	<i>MULTIPLE MYELOMA</i>	DUE TO (c)		10 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>705</b>		20f. (City or town) <b>Washington</b>	(County) <b>D.C.</b>	(State)
21 I certify that (I) (this hospital) attended the deceased from <b>705</b> , 19 <b>66</b> , to <b>11-26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-26</b> , 19 <b>66</b> , and that death occurred at <b>6A M</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Robert V. Choisser</i>		M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS			22b. DATE SIGNED <b>12/9/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert V. Choisser, M.D.</b>		22d. ADDRESS <b>1801 Eye St. N.W. Washington, DC.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-12-1966</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Creek Cemetery</b>	23d. LOCATION (City or Town) <b>Washington</b>		(County) <b>D.C.</b>	(State)
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		ADDRESS <b>5130 Wisconsin Ave. N.W. Wash. D.C.</b>		25a. RECEIVED BY REGISTRAR <b>✓</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE <b>12/9/66</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17480

## CERTIFICATE OF DEATH

17472

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Bethesda</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>2 mo 2da</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>		d. STREET ADDRESS <u>5618 LAMAR Rd.</u>				
3. NAME OF DECEASED (Type or print)	First <u>Victoria</u>	Middle <u>R. Reixach</u>	Last <u>Dec.</u>			
S. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2 1881</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>80 yrs.</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Spain</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. Naturalized</u>				
13. FATHER'S NAME <u>Henry</u>		14. MOTHER'S MAIDEN NAME <u>Frances Lartes</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>433-05-1104</u>	17. INFORMANT <u>Son</u> Bene H. Reixach			
		Address <u>SAME AS ITEM 2.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC DECOMPENSATION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		DUE TO <u>16 years</u>				
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/25</u> , 19 <u>66</u> , to <u>12/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/27</u> , 19 <u>66</u> , and that death occurred at <u>12/25</u> M, from causes and on the date stated above.						
22a. SIGNATURE <u>John E. Everett</u>		M.D. <input type="checkbox"/> ATTENDING PHYS	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>12-28-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>		22d. ADDRESS <u>9400 Conn. Ave.</u>		<u>Kensington, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1230-66</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Greenwood Cemetery</u>		23d. LOCATION (City or Town) <u>New Orleans</u>	(County) <u>La</u>	(State)
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		7557 <u>Wisconsin Ave</u>	25a. REC'D BY REGISTRAR <u>DEC 31 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>		



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17481

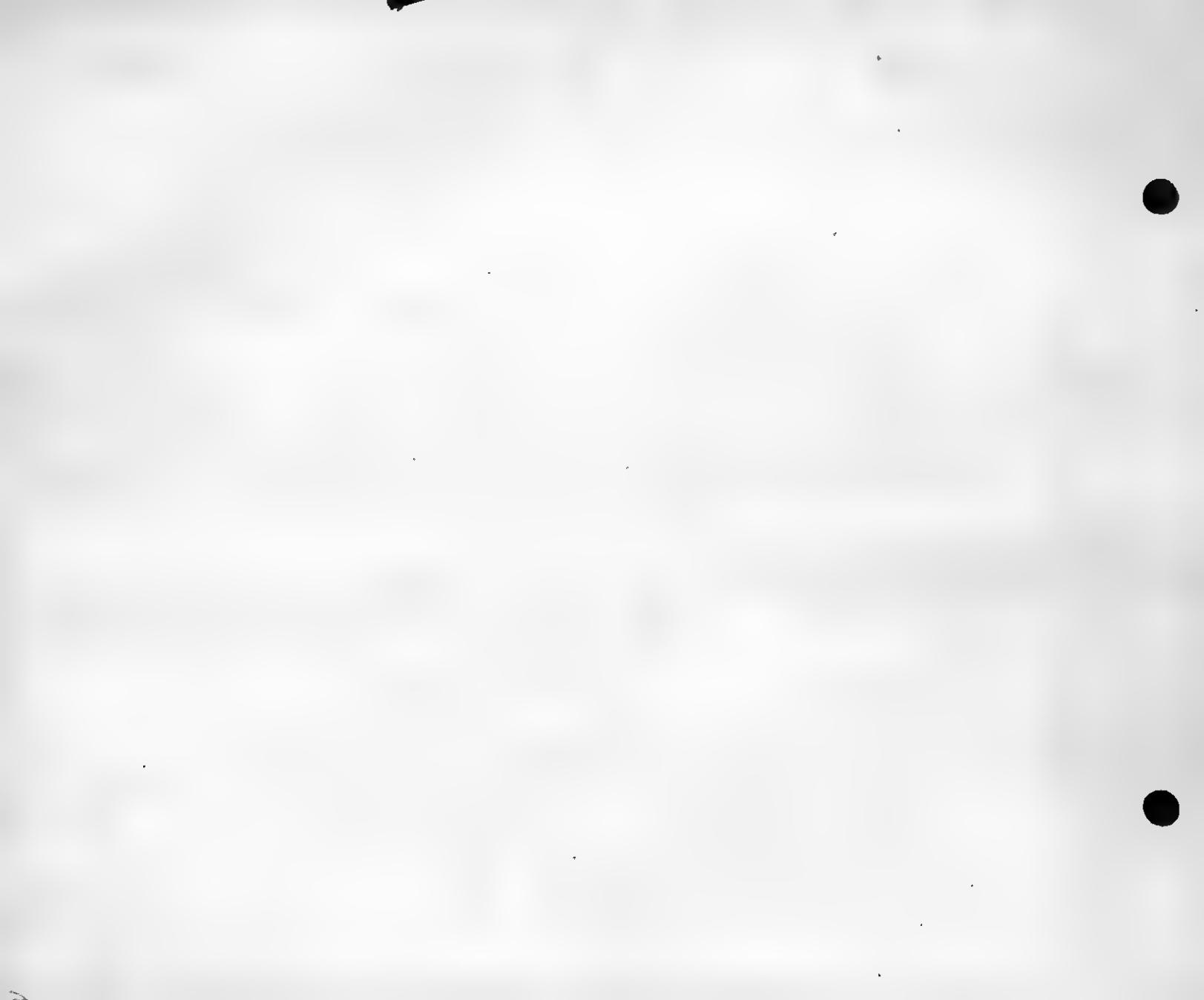
CERTIFICATE OF DEATH

17473

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			b. COUNTY <b>Montgomery</b>		
c. LENGTH OF STAY IN b. <b>20 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtonsville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>			d. STREET ADDRESS <b>14201 Sandy Spring Road</b>		
3. NAME OF DECEASED (Type or print) <b>William Christopher Renn</b>			4. DATE OF DEATH Month <b>December 8 1966</b>	Doy	Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <b>X NEVER MARRIED</b>	8. DATE OF BIRTH <b>12-06-92</b>	9. AGE (In years lost birthday) <b>71 yrs</b>	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>			12. CITIZEN OF WHAT COUNTRY? <b>America</b>		
13. FATHER'S NAME <b>Henry Renn</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Murphy</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO <b>213-36-3528</b>		
17. INFORMANT <b>Patient's chart</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Inanition + Cachexia</b>					
19.2 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO (b) <b>Metastatic Carcinoma to pelvis</b>					
DUE TO (c) <b>Primary site undetermined</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day Year Hour o.m. p.m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not White of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>OCT</b> , 19 <b>66</b> , to <b>Dec 7</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec 7 1966</b> , and that death occurred at <b>12:15 P.M.</b> , from causes and on the date stated above					
22a. SIGNATURE <b>Joseph E. Smith, Jr.</b>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Joseph E. Smith, Jr.</b>			22d. ADDRESS <b>Burtonsville, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-11-66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Union Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Burtonsville Md.</b>
24. FUNERAL DIRECTOR <b>Debra Roberts</b>		ADDRESS <b>313 Talbot St. Suite 4012 Laurel Md.</b>	25a. REC'D. BY REGISTRAR DATE <b>DEC 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. E. Smith, Jr.</b>



1  
to  
1  
FOR STATE  
HEALTH DEPT.  
Health or its designated agent, prior to burial, cremation, or removal,  
5 may be retained for your files.

Items 18-21 Film 385 1-26 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17482 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17474

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>Maryland</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hospital</u>		d. STREET ADDRESS <u>4 Springvale Lane</u>				
3 NAME OF DECEASED (Type or print) <u>Martha M. Obaxxoxox Repplier</u>		4. DATE OF DEATH Month Day Year <u>December 6 1966</u>				
S SEX <u>Fe</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>			
10a. US JAIL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>				
11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>A. S. A.</u>				
13 FATHER'S NAME <u>Charles Macatee</u>		14 MOTHER'S MAIDEN NAME <u>Martha Murphy</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>yes</u>				
17 INFORMANT <u>Theodore S. Repplier, Jr.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to plastic bag</u> DUE TO <u>919X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>being tied over head</u> DUE TO (c)				
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased tied plastic bag over head</u>				
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> 11 pm 12-5 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Silver Spring</u>	(County) <u>Mont.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <u>Belden R. Reap M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>Dec. 6, 1966</u>		
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Dec. 8, 1966</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) <u>Prince Georges Co.</u>	(County) <u>Md.</u>	(State)
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		ADDRESS <u>1615 N. St. N.E., 8434 Georgia Ave.</u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	DATE DEC 9 1966	
VR AISM 6M 1/66						



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17483

## CERTIFICATE OF DEATH

17475

Item 1c - 21m 6307 1/24/67 m

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
a. COUNTY	MARYLAND	a. STATE	b. COUNTY		
Montgomery	Pennsylvania	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	02	New Cumberland	25		
Bethesda	51 days	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		1203 Bridge Street	YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>		
The Clinical Center, Bethesda, Maryland		f. DATE OF DEATH December 13, 1966			
3. NAME OF DECEASED (Type or print)	First Mildred	Middle Helen	Last Reynolds		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS.
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	11 July 1911	55 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
Housewife		---		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		USA	
Ralph Steelman		Mary Elizabeth Schull			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes give war or dates of service)		201-18-9977		The Medical Record	
No		The Clinical Center, Bethesda, Md. 20014		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 205 X DUE TO (b) Mycosis Fungoides Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH 18 Hours					
3 Years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
White at work		Not White at work			
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from Sept. 22, 1966, to Dec. 13, 1966, that <input type="checkbox"/> (we) last saw the deceased alive on Dec. 13, 1966, and that death occurred at 3:45, from the causes and on the date stated above.					
22a. SIGNATURE William R. Levis					
AM 22b. DATE SIGNED 12/13/66					
22c. PHYSICIAN'S NAME (Type) William R. Levis, MD.					
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 16, 1966	23c. NAME OF CEMETERY OR CREMATORIUM St. Paul Cemetery	23d. LOCATION (City, town or county) Lower Alberts Gap, Carroll Co., Pa.	
(State)					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Maryland					
ADDRESS 1931 Rock Rd. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE TUEC 19 1956 Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17484

CERTIFICATE OF DEATH

17476

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>	LENGTH OF STAY IN lb <i>14 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lockville</i>	b. COUNTY <i>Montgomery</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Sugarbush</i>		d. STREET ADDRESS <i>213-Elizabeth Ave.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Glacier</i>	First <i>C.</i>	Middle <i>Rice</i>	4. DATE OF DEATH Month <i>Dec.</i> Doy <i>2</i> Year <i>1966</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/5/93</i>	9. AGE (in years last birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bus. Admin</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ed. of Education</i>		11. BIRTHPLACE (County & State, or foreign country) <i>North Carolina</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Clinton Rice</i>		14. MOTHER'S MAIDEN NAME <i>Sally Rice</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>165-111-1111</i>		17. INFORMANT <i>Anne Rose Moran Rockville, Md.</i>	Address <i>213-Elizabeth Ave.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>157X</i>		DUE TO <i>Pancreatic Carcinoma</i>		INTERVAL BETWEEN SET AND DEATH <i>End.</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i></i>		(b) <i></i>						
(c) <i></i>								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>act 15</i>		20f. (City or town) <i>10</i>	(County) <i>12/3/66</i>	(State) <i>1966</i>
21. I certify that (I) (this hospital) attended the deceased from <i>act 15</i> , 19 <i>66</i> to <i>12/3/66</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>12/3/66</i> , and that death occurred at <i>act 15</i> M, from causes and on the date stated above							22b. DATE SIGNED <i>12/3/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert C. Mecon</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/7/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Trinity Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Md.</i>		
24. FUNERAL DIRECTOR <i>George R. Snowden Rockville</i>		ADDRESS <i></i>		25a. REC'D. BY REGISTRAR <i></i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
25c. DATE DEC 7 1986								



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

17477

17485

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>North Carolina</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>35 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Maryland</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Raleigh</b>	
3. NAME OF DECEASED (Type or print) <b>Lula Belle Rich</b>		4. DATE OF DEATH Month Day Year <b>December 9 1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>31 December 1912</b>	
9. AGE (In years last birthday) <b>53 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>0 0 0 0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Health Educator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Health</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Highsmith</b>		14. MOTHER'S MAIDEN NAME <b>Lula V. Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>262-36-0198</b>	
17. INFORMANT <b>The Medical Records,</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>			
47 days DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypotension</b>			
DUE TO (c) <b>Fulminating pneumonitis, bilateral</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Disseminated Necrotizing Vasculitis 4 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>X</b> (this hospital) attended the deceased from <b>4 November, 1966</b> , to <b>9 December 1966</b> , that <b>W</b> (we) last saw the deceased alive on <b>9 December 1966</b> , and that death occurred at <b>9:05M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>David N. Sogho</b>		P.M. 22b. DATE SIGNED <b>12/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>David N. Sogho, M.D.</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS National Institutes of Health, The Clinical Center, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 12-10-66</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Oakwood Cemetery</b>	
23d. LOCATION (City, town or county) <b>Raleigh, North Carolina</b>		(State)	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE DEC 15 1956	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17486

## CERTIFICATE OF DEATH

17478

## 1. PLACE OF DEATH

## e. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - Boulderville

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2408 Seibel Drive

MARYLAND

## c. LENGTH OF STAY IN lb

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

## 5. SEX

F

## 6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

## 8. DATE OF BIRTH

April 30, 1879

9. AGE (In years  
last birthday)

87 yrs.

## IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

## 13. FATHER'S NAME

John Wm Parsley

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(yes, no, or unknown) (If yes, give rank or date of service)

## 10b. KIND OF BUSINESS OR INDUSTRY

at Home

## 11. BIRTHPLACE (County &amp; State, or foreign country)

Bethesda, Md.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 17. INFORMANT

Rebecca Gingle

Address

Mrs. Etta Miles, (same as #2)

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:  
DATE CAUSE (a)

293X

## DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Cardiac failure

INTERVAL BETWEEN  
ONSET AND DEATH19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Probable anemia

20a. ACCIDENT WAS UNDERLYING  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a.m. p.m.	19	While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				

21. I certify that (I) (this hospital) attended the deceased from 11-30-66, 19..., to 12-1-66, 19..., that (I) (we) last  
saw the deceased alive on 11-30-1966, and that death occurred at 5:30PM from the causes and on the date stated above.

## 22e. SIGNATURE

Milton N. Westberg

22c. PHYSICIAN'S  
NAME (Type)

M. Milton N. Westberg

22b. DATE  
SIGNED

M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	12-1-66
	22d. ADDRESS			

Boulderville Maryland

23e. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City, town or county)
Burial	Dec 3, 1966	Union Cemetery	Boulderville, Md.

## 24. FUNERAL DIRECTOR'S SIGNATURE

Arthur Waitz, 254 Carroll St. N.W. D.C.

## ADDRESS

25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DATE DEC 5 1966	Charles Judge



Items 18-21 Film # 5 2-10 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE  
HEALTH DEPT.

17487

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17479

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pen, in Item 1 in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1 PLACE OF DEATH a) COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if in institution, Residence before admission) b) STATE <i>Maryland</i>				
c) CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		d) COUNTY <i>Montgomery</i>				
c) LENGTH OF STAY IN b <i>Do A.</i>		e) CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <i>Takoma Park</i>				
d) NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San + Hosp.</i>		d) STREET ADDRESS <i>1001 Univ Blvd E. #101</i>				
3 NAME OF DECEASED (Type or print) <i>ANN ELIZABETH RICHARDS</i>		e) IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
4 SEX <i>F</i>	5 COLOR OR RACE <i>W</i>	6 MARRIED WIDOWED <input type="checkbox"/>	7 NEVER MARRIED DIVORCED <input type="checkbox"/>			
8 DATE OF BIRTH <i>Oct 5, 1918</i>	9 AGE (In years last birthday) <i>48 yrs</i>	10 MONTH <i>12</i>	11 DAY <i>24</i>			
12 IF UNDER 1 YEAR Months <i>0</i>	13 IF UNDER 24 HRS Days <i>0</i>	14 HOURS <i>0</i>	15 MIN. <i>0</i>			
10a US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b KIND OF BUSINESS OR INDUSTRY <i>at Home</i>				
11 BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY <i>A.S.A.</i>				
13 FATHER'S NAME <i>Mary Newman</i>		14 MOTHER'S MAIDEN NAME <i>Mary Newman</i>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <i>No</i>		16 SOCIAL SECURITY NO.				
17 INFORMANT <i>Robyn G. Baughman, 4505 Bang Sp. Court</i>		Address				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiorespiratory failure due to</i>						
DUE TO <i>1108</i> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.) { (b) <i>Overdose of Carbrital</i> DUE TO (c)						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						
19a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		19b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Deceased ie. ressed, took overdose of carbrital</i>				
20a TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> 9:00 p.m. 12-22 1966		20b INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20c PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Takoma Park</i>	(County) <i>MD.</i>	(State) <i>MD.</i>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				22. DATE SIGNED <i>12/26/1966</i>		
ACTUAL SIGNATURE <i>Belden Blask</i>		CHIEF MEDICAL EXAMINER <i>MD.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>BELDEN</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, City, Town, County) <i>1414 14th Street N.W. D.C.</i>		
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>Dec 28, 1966</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery</i>	23d LOCATION (City or Town) <i>Montgomery County</i>	(County) <i>MD.</i>	(State) <i>MD.</i>
24. FUNERAL DIRECTOR <i>Arthur Walters, 254 Carroll St N.W. D.C.</i>		ADDRESS <i>Arthur Walters, 254 Carroll St N.W. D.C.</i>		25a REC'D BY REGISTRAR <i>DEC 26 1966</i>	25b DATE <i>12/26/1966</i>	25c REGISTRAR'S SIGNATURE <i>John J. Hayes</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17488

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17480

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN lb <b>DOA</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital, Bethesda, Md.</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlotte</b>		
f. STREET ADDRESS <b>2116 Highland Street</b>			g. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>James Newton ROBERSON, JR.</b>			4 DATE OF DEATH Month Day Year <b>December 28 1966</b>		
S SEX <b>Male</b>	6 COLOR OR RACE <b>Cauc.</b>	7 MARRIED WIDOWED <b>Never married</b>	8 DATE OF BIRTH <b>May 20, 1927</b>	9 AGE (in years last birthday) <b>39 yrs</b>	F UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>			10b KIND OF BUSINESS OR INDUSTRY		
11 BIRTHPLACE (State or foreign country) <b>Morehead City, N. C.</b>			12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James Newton Roberson, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Elsie Pate</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>Yes 1945-1966</b>			16 SOCIAL SECURITY NO <b>244-22-8766</b>		
17 INFORMANT <b>Navy Records</b>			Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute hemorrhagic pancreatitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Massive fatty metamorphosis of the liver</b> DUE TO Conditions, if any, which gave rise to underlying cause (b), stating the primary cause (c) <b>Acute and chronic alcoholism</b> INTERVAL BETWEEN ONSET AND DEATH <b>581.1 24 hr?</b> <b>years</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or Town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John G. Ball, M. D.</b>		22. DATE SIGNED <b>12/29/66</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>1/3/67</b>	23c NAME OF CEMETERY OR CREMATORIAL <b>-</b>	23d LOCATION (City or Town) (County) (State) <b>Charlotte, N.C.</b>	
24 FUNERAL DIRECTOR <b>W. W. Chambers Co.</b>		ADDRESS <b>1400 Chapin St., N.W., Washington, D.C.</b>		25a REC'D BY REGISTRAR <b>Charles Judge</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>
				DATE <b>JAN 3 1967</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

17489

## CERTIFICATE OF DEATH

17481

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner - M

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>1008 Debeck Drive</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>EARL</b>	Last <b>ROBERTSON</b>	4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>10</b>	Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>Oct. 6, 1930</b>	9. AGE (in years less birthday) <b>36 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Frostburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Archie Rankin</b> Cora Regina Robertson								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>220-26-9262</b>		17. INFORMANT <b>Mrs. Cora Ort - 1008 Debeck Dr.</b>		Address <b>Rockville, Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cordis Standstill</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 Minutes</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO (b) <b>Kinnarot/Wilson syndrome. Uremia</b> Anemia <b>Acute anemia</b> DUE TO (c) <b>Diabetes Mellitus. Arterial Hypertension</b> <b>Arteriosclerosis</b> <b>22 years t.</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.      19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frostburg</b>	(County) <b>Maryland</b>	(State) <b>MD</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 19 <b>66</b> , to <b>December</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>December 8, 1966</b> , and that death occurred at <b>9:35PM</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>Hugo G. Graziani</b>		M.D. <input type="checkbox"/> ATTENDING PHYS MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <b>December 10, 1966</b>	22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>HUGO G. GRAZIANI</b>		22d. ADDRESS <b>Holy Cross Hospital, Silver Sp., Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/14/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Frostburg Mem. Park</b>		23d. LOCATION (City or Town) <b>Frostburg, Maryland</b>			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS <b>1351 Rockville Pike</b>	25a. REC'D BY REGISTRAR <b>DEC 15 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				
VR A15 (4) 20 M 1/66		DATE						



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

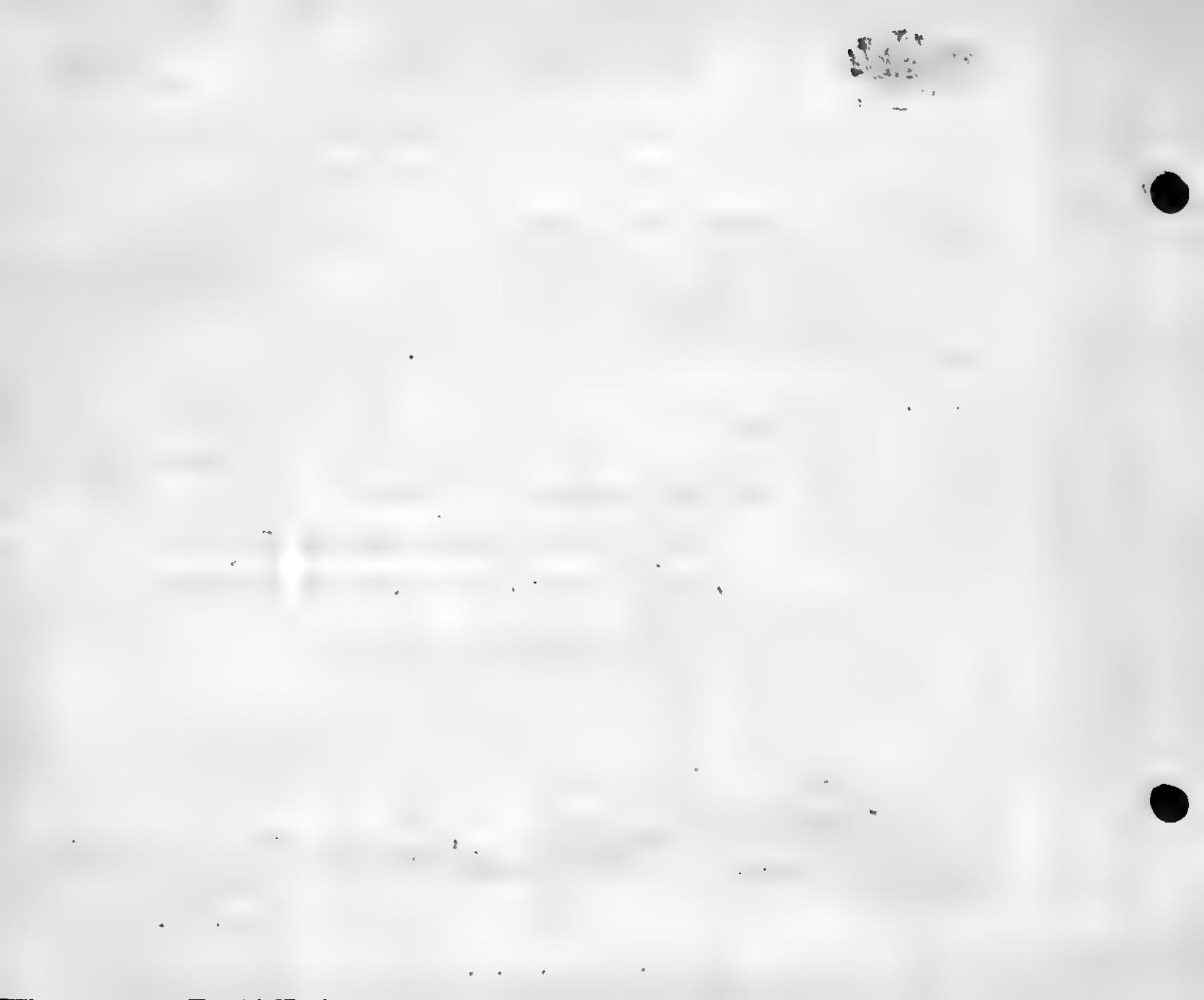
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17490

17482

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FENSINGTON</i>		c. LENGTH OF STAY IN 1D <i>6 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>KENSINGTON GARDENS SANITARIUM</i>		d. STREET ADDRESS <i>1890 Battery Lane</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>KENSINGTON GARDENS SANITARIUM</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>EDITH FENNYC</i>		First <i>C</i>	Middle <i>ROGERS</i>
Last <i>DECEMBER 30, 1966</i>		4. DATE OF DEATH <i>DEC. 30,</i>	Month <i>Dec.</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>9-28-1894</i>		9. AGE (In years last birthday) <i>72 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <i>2</i> Days <i>22</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEMOTHER</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>BOSTON, MASS.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>RANSOM COOKE</i>		14. MOTHER'S MAIDEN NAME <i>MATILDA SIMPSON</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>AUDREY R. CASSELBERRY</i>	
17. INFORMANT <i>AUDREY R. CASSELBERRY - BETHESDA, MD</i>		Address <i>4840 BATTERY LANE</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Acute Congestive Heart Failure</i> (c) <i>Arteriosclerotic Heart Disease</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>4200</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20d. INJURY OCCURRED Hour a.m. <i>19</i> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>p.m.</i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i> Address (Street, city, town, or county) <i>Washington, D.C.</i>			
22. DATE SIGNED <i>12/21/1966</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>12-22-66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Cedar Hill Crematory</i>		23d. LOCATION (City, town or county) (State) <i>Suitland, Md.</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawlers Sons, Inc. Wash., D.C.</i>		25a. REC'D BY REGISTRAR <i>REG'D 29 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17491

CERTIFICATE OF DEATH

17483

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN lb <u>3 1/2 hrs</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PG</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WICH SANITARIUM CARROLL AVE</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		f. STREET ADDRESS <u>1804 AMHERST RD</u>	
3. NAME OF DECEASED (Type or print) <u>GORDON TOWNSEND Rosborough</u>		First <u>GORDON</u>	Middle <u>TOWNSEND</u>	Last <u>Rosborough</u>	4. DATE OF DEATH <u>12-16-66</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH <u>10-31-30</u>	9. AGE (In years last birthday) <u>36 yrs.</u>	10. IF UNDER 1 YEAR Months <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sgtt Engr Dept of Defense</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HERBERT Rosborough</u>		14. MOTHER'S MAIDEN NAME <u>LUCY ALDAY</u>	
15. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Army 52-57</u>		16. SOCIAL SECURITY NO. <u>205 22 5691</u>		17. INFORMANT <u>Chart</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause <u>Arteriosclerotic heart disease</u>		DUE TO (b) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years.</u>	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6864 New Hampshire Ave Tak Pk MD</u>	
20f. (City or town) <u>12-6-66</u>		(County) <u>12-6-66</u>		(State) <u>12-6-66</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12-6-66</u> , to <u>12-6-66</u> , that (I) (we) last saw the deceased alive on <u>12-6-66</u> , and that death occurred at <u>6:25 M</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Harvey Oberman</u>					
22b. DATE SIGNED <u>12-6-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Harvey Oberman</u>		22d. ADDRESS <u>6864 New Hampshire Ave Tak Pk MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 9, 1966</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Arlington National Cemetery</u>	
23d. LOCATION (City or town) <u>Arlington</u>		(County) <u>Virginia</u>		(State)	
24. FUNERAL DIRECTOR <u>Arthur Welles</u>		ADDRESS <u>254 Carroll St NW</u>		25a. REC'D. BY REGISTRAR <u>REC'D. BY REGISTRAR</u>	
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		DATE <u>DEC 9 1966</u>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17492

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17484

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b> Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			c. LENGTH OF STAY IN lb MARYLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
71			15-1		
3. NAME OF DECEASED (Type or print) <b>Viola Ruth Ross</b>			4. DATE OF DEATH 12 28 1966	Month	Year
S. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-4-11</b>	9. AGE (In years last birthday) <b>55 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Mckinney, Benjamin</b>			14. MOTHER'S MAIDEN NAME <b>Mary Harriet</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>MRS Geneva Cross - Sister</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide intoxication,</b> 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>burns and smoke inhalation</b> DUE TO DUE TO (c) <b>due to house fire</b> DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased burned in house fire</b>		
20c. TIME OF INJURY Month, Day, Year Hour <b>pm.</b> 4:00 12-28 1966			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Takoma Park</b> (County) <b>Montg.</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Belden R. Keap</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>BELDEN R. KEAP M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			Address (Street, City, Town, or County) <b>Charter Memorial Park Laurel Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/28/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Charter Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Laurel Md.</b>	
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md.</b>	25a. REC'D BY REGISTRAR DATE JAN 5 1967	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
B8					

4/15/

4/15/1971

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17493

## CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>DoA</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		e. STREET ADDRESS <i>6621 Michaels Dr</i>	
3. NAME OF DECEASED (Type or print) <i>Percy Hale Royster</i>		First <i>Percy</i>	Middle <i>Hale</i>
4. DATE OF DEATH <i>Dec. 25 1966</i>		Month <i>Dec.</i>	Year <i>1966</i>
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>7/21/1888</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) yrs. <i>78</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Rawleigh North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>V.C.</i>		14. MOTHER'S MAIDEN NAME <i>Hallie High</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Ann E. Royster, Same as # 2</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>5271</i> (b) - <i>CHRONIC OBSTRUCTIVE EMPHYSEMA, complicated by pulmonary infection</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>SUDDEN DEATH</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Dr John Ball, coroner was notified and gave us permission to sign the death certificate</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Sign the death certificate</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) <i></i>	
(State) <i></i>			
21. I certify that <i>we</i> (this hospital) attended the deceased from <i>1956</i> , 19, to <i>PRESENT</i> , 19, that <i>we</i> (we) last saw the deceased alive on <i>NOV 1966</i> , and that death occurred at <i>55 1/2 M.</i> from causes and on the date stated above.			
22. SIGNATURE <i>Oscar Mann</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>OSCAR MANN</i>		22d. ADDRESS <i>1150 CONNECTICUT AV. WASH. D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>12/27/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>
24. FUNERAL DIRECTOR <i>Jos. Gowler &amp; Son Inc. Wash. D.C.</i>		ADDRESS <i></i>	25a. LOCATION (City or Town) <i>Suitland Maryland</i>
		25b. REC'D BY REGISTRAR <i>JAN 3 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>

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